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## *Executive Summary*

### **Need for Change and Challenges Ahead**

Over the years, we have developed an enviable health care system in Hong Kong but these quality services do not come cheap. In 2004-05, the expenditure on public health care services totaled \$30.2 billion and constituted 14.4% of the recurrent public expenditure. Of every \$100 received from tax revenue, about \$22 was spent on public health care – a ratio which is among the highest in developed economies. A main reason is that our heavily subsidised public health care services take care of most of the more expensive hospital services vis-à-vis the private sector. The Hospital Authority (HA), our main public health care service provider, saw an increase in expenditure from \$14.5 billion in 1994-95 to \$27.8 billion in 2004-05. The community has to consider whether we should continue to put a larger and larger proportion of public expenditure on public health care services at the expense of other services and infrastructure development.

2. Specifically, challenges faced by the present system include –
  - over-reliance on the public health care system which is heavily subsidised;
  - an ageing population – 1 in 5 will be over 65 by 2023;
  - tendency of early occurrence of chronic illnesses in the population resulting in prolonged reliance on the public medical system;
  - advancement in medical technology leading to increasing number

- of treatable medical conditions at high costs;
- over-stretched hospital services.

### **The Price of Inaction**

3. If we do not address the above situation and reform our service models, we project that Government would have to spend well above \$50 on health care services out of every \$100 tax revenue collected by 2033 to provide the health care services currently provided. Furthermore all additional resources, if any, would be absorbed by the increasing demand. There would be no spare resources to improve on the existing system. The private medical workforce would shrink and the public medical workforce would have to face an increasingly heavy workload with insufficient manpower. The community would have little choice but to remain with or revert to the public health care sector. This would end up in a vicious cycle. In time, there would not be sufficient incentives for young persons with good potentials to join the health professions.

### **Time for Change**

4. Our shared vision is to ensure that the community will continue to enjoy quality health care service which is sustainable, affordable and accessible to all. To this end, we have a shared mission – to critically review and re-think what our future health care model should be so that our vision can be attained.

## **Future Service Delivery Model**

5. We believe that our future health care model should include the following elements –

- (i) A population knowledgeable about health and health risk factors, will adopt a healthy lifestyle, and take responsibility for their own health.
- (ii) A health care profession that views health promotion and preventive medicine as priorities, and exercises its practice professionally and ethically.
- (iii) A primary health care system which can provide a robust family and community medicine service affordable by all, whilst incorporating strong elements of health promotion and preventive care, with standards set for the care of different age groups and health status.
- (iv) A hospital service network which can provide emergency and secondary care within reasonable reach of the population in all districts, in order to enhance service access and family visitation.
- (v) Elderly, long-term and rehabilitation care services which encourage home care with community outreach and professional support, with infirmary and hospice care in all districts to enhance maintenance of family support.
- (vi) The establishment of specialized tertiary centres and hospitals to develop and concentrate expertise, technology, special facilities and research for the treatment of catastrophic illnesses.
- (vii) Well-integrated public and private sectors which promote healthy competition for service quality and professional standards, and

provide a choice for the public.

- (viii) A financing model which encourages appropriate use of health care services, ethical and effective professional care, reasonable and affordable contributions by users, and with targeted subsidies through public funds for unfortunate patients and families in genuine need.

### **Positioning of the Public and Private Sectors**

6. It is also important to re-align the roles of the public and private sectors in developing our future health care model. To ensure that our limited resources are being utilized in the most appropriate manner and for those in genuine need of such service, we believe that our public health care service sector should target its services at the following areas –

- acute and emergency care;
- for low income and under-privileged groups;
- illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and
- training of health care professionals;

whereas our private sector should be one that –

- provides comprehensive, personal and quality care to patients;
- provides choice for the community;
- is affordable by people of average income level;
- attracts young members of the health care professions; and
- contributes towards the training work for health care professionals.

## **Changing Needs of the Patient – Different Levels of Care**

7. Health care is a continuing and developing process. We have to develop a future health care model that is capable of responding flexibly to the changing needs of the patient by providing him / her with the appropriate level of care – primary, secondary or tertiary – either through the private or public sector. To make the best use of resources, the system should encourage “smooth transition” of patients between different levels or types of care in response to changing care needs.

## **Primary Medical Care Services**

8. Primary medical care is the first point of contact individuals and the family have in a continuing health care process and is the base upon which the rest of the health care system is organized. It should provide continuing, comprehensive and whole-person medical care to individuals in their home environment. Effective primary medical care services will be able to improve the health of the population as well as to reduce pressure on the hospital system.

## **Present Phenomenon**

(i) *Importance of continuity of care not fully recognized*

9. A continuing relationship between the primary care doctor and the patient is essential in that the doctor is familiar with the patient’s medical history, lifestyle and other factors that may affect his / her health and is able to recommend the best course of preventive action or treatment. However, Hong Kong’s culture has all along emphasized quick cure.

*(ii) More emphasis on prevention needed*

10. At present, the community is not sufficiently aware of the merit of and opportunities for receiving preventive services in primary medical care. Preventive services like screening for risk factors, detection of early symptoms and signs of disease, and assessments and corrections of health risk are not often given sufficient emphasis by both doctors and patients.

*(iii) Gate-keeping role / first-point-of-contact role needs strengthening*

11. Primary care doctors should be the first point of contact for patients in most circumstances, including in acute conditions and when a decision is needed as to whether specialist care is required. They help patients to act most appropriately based on sound medical advice, prevent unnecessary investigation and treatment, and ensure that resources of both the patient and the hospital are used in the most appropriate manner. They should also be the long-term carers of patients with chronic disease whose conditions have stabilized. At present, many patients do not perceive primary care doctors to be having this role.

*(iv) More collaboration with other professionals required*

12. Whole-person care requires comprehensive and thorough understanding of the patient's problems that affect his / her health and deriving solutions that resolve these problems. At present, problems beyond the patient's physical condition which nevertheless affect his long-term health status, e.g. occupational hazard, psychological problems, are seldom dealt with fully. There is not much collaboration between health care professionals and other professionals in the investigation and

resolution of the patient's overall problems.

## **Consequence**

13. As a result, we have not been able to achieve the best health outcome for our population; time and resources are at times wasted on investigations that are not necessary; and there is a more expensive health bill for the patient and the community as a whole.

## **Recommendations on How to Move Towards the Future Model**

### *Promoting the family doctor concept*

14. We recommend the Government and the medical profession to devote more efforts to promote the family doctor concept. A family doctor can be a general practitioner, a family medicine specialist or any other specialist. The important point is for the patient to have a continuing relationship with the doctor of his / her choice, and that the doctor has the mindset and training of managing problems at the primary care level in a holistic way. The family doctor should be the one to whom the patient turns when in need of medical assistance or advice and the one most familiar with his / her medical history and factors that affect his / her health. Patients should be able to derive maximum benefit through enjoying continuity of care with their family doctors. For patients' trust in primary care doctors as family doctors to be enhanced, we recommend these doctors to expand their modes of operation, e.g. by offering medical advice or even consultations beyond normal clinic-opening hours and by

incorporating a larger element of preventive care in attending to patients.

*Provision of information by government to improve preventive care*

15. Greater emphasis should be placed on preventive care. We recommend the Government to enhance the identification and assessment of the impact of social and environmental variables on health and the communication of this information to family doctors, and to launch more public education on prevention of diseases and illnesses.

*Establishment of a platform on a regional / district basis to facilitate collaboration among medical and other professionals*

16. We recommend the Government to draw together family doctors in private practice, primary care doctors of the public sector and other professionals working in each region / district and provide a platform for them to share observations, exchange information, as well as to alert and refer cases to each other with a view to taking care of the population's needs from all possible angles.

*Purchasing primary medical care service from the private sector*

17. We recommend the Government and HA to consider providing part of its primary medical care service through purchasing such service from the private sector. By so doing, the public sector can set requirements and standards of practice which will in time become a benchmark for primary medical care in Hong Kong.

### *Development of the private sector in primary medical care*

18. We recommend the private sector to take actions to enhance confidence amongst patients, such as pursuance of continuous medical education and devoting more time to educate patients to manage their own health problems. We also recommend private sector family doctors to consider working together in group practice which offers the advantages of reduced overhead costs, enabling the sharing of resources and equipment, and providing coverage for leave-taking. More importantly, doctors in group practice will influence each other's clinical behaviour and thus promote sharing of desirable practices.

### *The community to change old perceptions*

19. Patients should recognize the importance of continuity of care, the importance of disease prevention and a healthy lifestyle. They have to change their understanding and expectation of what primary medical care offers to derive maximum benefit from this level of care.

## **Hospital Services**

20. Hospital services can be broadly classified into three categories – A & E service, specialist out-patient service and in-patient service.

## **Review of Hospital Services Provision**

21. There is an average of 3.4 (public and private) acute and convalescent hospital beds per 1 000 population in Hong Kong. The 14

acute hospitals under the HA are strategically located in densely populated districts and covered by an efficient transportation network and high-performance ambulance service. Under HA's cluster structure, all the acute hospitals are supported by smaller-sized non-acute hospitals in each cluster.

22. In terms of accessibility, the present public hospital networks are able to ensure emergency and secondary care to be within reasonable reach of the population in all districts. However, the number of A & E attendances and proportions of truly emergency cases vary among different acute hospitals. For the specialty services provided in acute hospitals, Medicine, Orthopaedics and Surgery have seen the highest demands, but the service volume of some other specialties is low.

## **Recommendations on How to Move Towards the Future Model**

### *Planning considerations*

23. The current planning standard for hospital beds is 5.5 beds (including all types of hospital beds and beds in both the public and private sectors) per 1 000 population. We recommend that the future planning of hospital bed provision in individual districts / regions should take into account multiple factors including population size (in particular the elderly population), expected changes in population demographics, utilization rate of beds in hospital in the same and neighbouring districts, utilization patterns of different age groups and gender, income distribution in the district / region, advances in medical technology and availability of private

hospital beds in the district and their utilization.

#### *Current and future A & E service*

24. We observed that some hospitals are having particularly low A & E attendances and low proportion of real emergency cases. We recommend the HA to review the critical mass of demand by A & E departments to identify the need for merging or other forms of rationalization, in order to ensure an optimal provision of A & E service for all districts. We also recommend HA to identify several district-based hospitals to be designated as specialized emergency centres with enhanced accident and emergency capabilities in their A & E departments, a comprehensive range of specialty services and higher levels of intensive care facilities.

#### *Supporting specialties*

25. For acute hospitals, we recommend that they should be equipped with the basic infrastructure of A & E departments, with on-site support from core specialties including Medicine, Orthopaedics and Surgery. Other specialties such as Gynaecology, Paediatrics and Neurosurgery with low service volumes should be provided through networks comprising several hospitals. We also recommend HA to monitor the number of A & E admissions in this latter group of specialties, and identify room for further service rationalization.

#### *Other measures to maximize hospital resources*

26. We also encourage public hospitals to continue to develop and

adopt advanced technology which will bring about reduction in the length of hospital stay. We recommend the public sector to co-ordinate the planning and development of ambulatory services with private hospitals so that resources in the two sectors can be maximized.

## **Current Patterns of Hospital Services Utilization**

### **Present Phenomenon (i) and Consequence**

#### *(i) Inappropriate use of hospital services and under-utilization of primary medical care services*

27. About 70% of patients attending A & E departments in 2004 were suffering from non-emergency conditions. As a result, resources are over-stretched; efficiency of care for patients with genuine emergency conditions is affected; and patients with non-emergency conditions have to endure long waiting times. At the other end, family doctors, who are in the best position to advise their patients and to effectively manage non-emergency cases, are under-utilised.

28. For SOPDs, there has been a 50% increase in the number of attendances, attributable, to a large extent, to an accumulation of “old” patients, some of whom have been followed-up at SOPDs for years even though their medical conditions have long stabilized and no longer require specialist care. As a result, the waiting time for and the waiting list of newly referred patients are becoming increasingly long.

## **Recommendations on How to Move Towards the Future Model**

### *Family doctors to play gate-keeper role*

29. We recommend that family doctors should play more prominent roles as gatekeepers of the hospital system. They may inspire reliance amongst patients by, e.g. providing their patients with outside-consultation-hour contact telephone numbers, so that patients will see them as a true recourse when they are in acute conditions. We also recommend the private sector to establish more 24-hour clinics to deal with acute but non-emergency cases. As a first step, family doctors in solo practice within a district may collaborate to take turns to provide service beyond normal clinic opening hours. 24-hour clinics may also consider strengthening their manpower resources with clinicians in the private sector who had undergone A & E training and their clinic set-up with simple diagnostic facilities.

30. We appreciate that patients would be worried that consulting their family doctors or visiting 24-hour clinics may delay treatment in the cases of real emergency conditions. To address this concern, we recommend A & E departments of public hospitals to share with family doctors and 24-hour clinics triage criteria and waiting time for different triage categories, and to establish links and protocols with them to enable real emergency cases they refer to A & E departments be attended to expeditiously. We also recommend private hospitals to consider developing formal A & E service.

### *SOPDs of public hospitals to discharge medically stable patients*

31. We believe that an explicit policy should be made to facilitate public hospitals to perform their rightful role of providing short-term and specialized care for complicated medical conditions. For chronic patients who are medically stable, we recommend public hospitals to make it an explicit policy to refer them back to their family doctors or their referring doctors in public or private primary care services. We recommend public hospitals to establish referral protocols and shared-care programmes with family doctors to reassure patients that, under appropriate conditions, they will have access to specialist care again. We also recommend the private sector to take an active part in establishing and implementing with the public sector referral protocols and shared-care programmes.

### *Other changes needed*

32. For this model to be successfully implemented, the Government should review the fees and charges of A & E service, SOPD service and drug supply of public hospitals, such that hospital services will not cost significantly less compared to a family doctor's service. This step is essential towards minimising the unnecessary attraction for patients to utilise public hospital services even though their conditions could be more appropriately and effectively managed by family doctors. The community also needs to change some entrenched perceptions, such as seeing A & E departments as the only resort after normal clinic-opening hours, and seeing specialists care as being better than primary care.

## **Present Phenomenon (ii) and Consequence**

### *(ii) Imbalance between the public and private medical sectors*

33. At present, over 80% of patients requiring hospitalisation turn to public hospitals with the expectation that they will receive highly subsidised, low price and high quality service. The current hospital utilisation pattern has resulted in a huge imbalance in the market share between public and private hospitals. The high occupancy rate of public hospitals leaves little flexibility to respond to changing needs of patients or emergency events such as outbreaks of infectious diseases.

## **Recommendations on How to Move Towards the Future Model**

34. We recommend the public hospital system to re-focus its services to the four target groups while private hospitals should take on a more active role in the provision of hospital service.

### *Measures that the public sector should take*

35. We believe a change in the current fees and charges policy to reduce subsidy levels for patients / services that do not belong to the four target groups will help re-dress the imbalance. Other measures we recommend for the public sector include co-ordinating with private hospitals the planning and further development of ambulatory services (so that there would not be over-provision of such services) and the procurement of drugs and equipments (to help reduce cost for the private sector). Public hospitals may also consider operating more shared-care

programmes, whereby the public and private sectors are each responsible for one part of the management of a specific patient.

*Measures that the private sector should take*

36. The private medical sector may consider developing services which are more affordable to patients, e.g. day surgery and other ambulatory services. In addition, private hospitals and doctors should improve the transparency of their fees and charges, and enhance their clinical governance. We also recommend the private sector to work with the insurance sector to bring about changes to insurance practices, thereby creating a larger market for the private sector.

**Tertiary and Specialized Services**

37. Tertiary and specialized services refer to services requiring highly complex and specialized care, usually through the application of advanced technology and specialized multi-disciplinary expertise. The cost incurred by the provision of these services is inevitably high due to the requirement of major capital investment and multi-disciplinary expertise.

**Present Phenomenon**

(i) *Public hospitals being the main Provider and services provided at highly subsidized rate*

38. At present, almost all tertiary and specialized services are provided at highly subsidized rates in public hospitals. They are concentrated in specific designated hospitals including the two Universities' teaching

hospitals and several major hospitals.

*(ii) Increasing demand for tertiary and specialized services*

39. The ageing population, technology advancement and rising public expectation are contributing to an increasing demand for tertiary and specialized services. The cost of providing such services is expected to increase exponentially in the future.

**Consequences**

40. It will be increasingly difficult for the public purse to meet the demand arising from both common and relatively easy-to-treat diseases that affect a large number of patients as well as catastrophic illnesses that affect a small number of patients.

**Recommendations on How to Move Towards the Future Model**

41. We recommend that the Government should commit to providing tertiary and specialized services and to ensure that such provision is sustainable and affordable.

*The role of prevention*

42. Prevention is the best cost-containment measure. We recommend the Government to develop a more aggressive prevention strategy and instil in patients a sense of responsibility for their own health.

### *A larger patient co-payment element*

43. We recommend that the Government should continue to provide tertiary and specialized services at a relatively higher subsidy rate. However, we believe there is room for a larger co-payment portion by patients primarily to heighten their awareness of the real costs of such services. Nonetheless, there should be a cap on the percentage of the patient's income and assets to be used as co-payment to limit the drain on the patient's resources by the treatment.

### *Other sources of funding*

44. We recommend that the Government should also look to other sources to fund tertiary and specialised services and related research. The Government may, for instance, encourage the establishment of foundations to support centres providing tertiary services.

### *Maintaining a high standard*

45. We recommend that the Government should encourage local research and collaboration among the public medical sector, universities and the private medical sector. The Government should also encourage the collation of relevant data to assess the needs of the local community for better planning of these services.

### *Concentration of experience*

46. We recommend HA to continue the current approach of

consolidating tertiary services in designated centres. Nevertheless, planning guidelines based on caseloads and training demand should be worked out and be reviewed from time to time.

#### *Public-private collaboration*

47. We believe the Government should encourage the private sector to develop tertiary services to help meet part of the demand, and HA should continue to collaborate with the public medical sector to provide tertiary services to the community. To make the best use of the small number of doctors trained in tertiary services, we recommend the public sector to consider engaging private sector doctors with experience in such services to practice in public hospitals on a part-time basis when public hospitals face shortage of such skills.

### **Elderly, Long-term and Rehabilitation Care Services**

#### **Present Phenomenon**

(i) *Insufficient professional support and facilities for patients' convalescence and rehabilitation outside hospitals*

48. At present, patients who can be discharged from hospitals but still require a high level of nursing and personal care do not have appropriate institutions to turn to if the care they need cannot be provided at home.

(ii) *On-site regular medical care for the elderly in residential care homes needs strengthening*

49. Regular medical care services for the elderly in most residential

care homes for the elderly (RCHEs) can be improved. The existing licensing requirement for RCHEs in terms of medical care only stipulates that they should ensure their residents receive medical check-up at least once a year. Not all RCHEs provide on-site regular medical care for their residents. They rely heavily on the medical support provided by HA's out-reaching Community Geriatric Assessment Teams. They also rely on A & E departments of public hospitals to treat acute illnesses of their residents, and public SOPDs to manage their chronic illnesses.

*(iii) Insufficient manpower for geriatric nursing and for providing nursing care in the community setting*

50. Much of the work involved in rehabilitative care, care for the elderly and people with disabilities (particularly in the management of stable chronic illnesses) can, in fact, be done effectively by qualified nurses. However, the scope of the Community Nursing Service (CNS) of the HA is not wide enough and few nursing graduates are interested in working in RCHEs.

### **Consequences**

51. Medically stable patients requiring some rehabilitation and nursing or long term care tend to stay for a prolonged period in public hospitals because of insufficient post-discharge convalescent and rehabilitation support and facilities outside the hospital setting. There are frequent admissions and readmissions of RCHE residents to public hospitals.

## **Recommendations on How to Move Towards the Future Model**

### *RCHEs to strengthen on-site regular medical care*

52. We recommend the Government to consider changing the licensing condition of RCHEs to require them to engage doctors to take care of their residents' medical needs on a regular basis. We note that the Social Welfare Department is in the process of revising the Code of Practice for RCHEs to encourage more frequent visit by doctors engaged by RCHEs and we welcome this move. With RCHEs taking on greater responsibility for medical care of their residents, we recommend CGATs to concentrate on discharge planning and providing support to doctors engaged by RCHEs. Good co-operation and interface between CGATs and doctors engaged by RCHEs can be achieved by developing and adopting shared care programmes and referral protocols. We also recommend the same model to be adopted by residential care homes for the disabled.

### *Short-stay institutions providing convalescent and rehabilitation services*

53. We recommend the private and social welfare sectors to develop a new type of short-stay institutions providing temporary convalescent and rehabilitation services. We also recommend the public sector to expand its CNS to enable it to take up comprehensive primary care roles. Doctors in private practice are encouraged to refer deserving cases to CNS. The public sector may also make greater use of allied health professionals to design and implement home rehabilitation programmes.

*Training more community nurse and health care workers for geriatric caring*

54. To meet the demand for nursing care arising from an ageing population, we recommend universities and training institutions to consider additional training and qualifications for those who would like to pursue a career of community nurse. Making reference to overseas experience of training a special type of health care workers with the capability to take care of elderly independently, we recommend tertiary education institutions to consider offering similar training programmes.

**Infrastructural Support**

55. Our future service delivery model has to have the following infrastructural support –

*A more aggressive prevention strategy*

56. We recommend the public sector to review its strategies in delivering preventive care at all levels and explore whether there is room for more collaboration with the private sector. For the private sector, we believe that their services should be re-oriented from curative care to paying greater attention to primary and secondary level preventive activities and health maintenance.

*Promotion of free flow of patient records*

57. In order that our future service delivery model can facilitate the transition of patients between different levels of care and between the

public and private sectors, it is essential to develop a system which enables free flow of patients' records with the patient's consent. We believe that the public sector should take the lead to create an environment that encourages and a system that facilitates the free flow of patients' medical record. The short-term aim should be to provide patients of all General Out-patient Clinics and SOPDs with hand-held record and to encourage private care doctors to do the same. In the long term, a territory-wide information system should be developed for carers in both public and private sectors to enter, store and retrieve patients' medical record.

#### *Training for professionals in different roles*

58. We suggest training institutions as well as the professions themselves to review the content of the training currently offered to undergraduates and in-service professionals to prepare them for the challenges ahead. The professions should also positively consider how best to ensure continuous education of their members.

#### *Fees and charges policy*

59. We believe that the Government should put in place a fees and charges policy that is conducive to the re-positioning of public health care services. We also recommend that a more refined assessment be developed to determine the financial needs of patients and to enable different subsidy level to be provided for patients with needs of differing degrees.

## *Public education*

60. We believe that there should be a rigorous public education programme which seeks to correct certain misconceptions commonly found; inculcate in patients a sense of responsibility for one's health and the awareness that one must seek the right level of medical help and the right person to help; and bring home to patients the importance of prevention and a healthy lifestyle.

## **Conclusion**

61. “What will Hong Kong's health care scene be like in 10 – 15 years' time if the recommendations in this Report are successfully implemented?”

- “Every family or citizen of Hong Kong is under the continuous care of a named doctor of his / her choice, who is located mostly close to his / her home.
- More preventive care is provided to patients. There are regular health checks, depending on age, past health history, and family history for every person, available at a moderate price.
- A territory-wide medical record system is in place. With patients' consent, doctors in the public and private sectors can all access their patients' records and make better informed treatment decisions.
- Patients can have access to hospitals of their choice when in need, and enjoy close links with their respective carers.
- 24-hour community clinics offer useful service to patients with acute conditions. Many family doctors are also willing to offer assistance to

- patients with acute conditions after their clinics' opening hours.
- Emergency cases are treated by A & E departments in a most timely manner. The effective use of observation wards has significantly reduced the need for admission through A&E departments.
  - Services for the elderly, chronically ill and rehabilitating patients reach out to the community. Visiting medical, nursing and allied health teams reach out to residential care homes or families.
  - Elderly individuals rarely need to be admitted through A&E departments just for diagnostic exclusion. All RCHEs have their own primary care doctor looking regularly after the medical needs of their elders.
  - With an appropriate fee differential system, there is better private-public market distribution, and room for development of tertiary services and centres of excellence, in both public and private institutions and facilities.
  - Patients with chronic illnesses are being cared for by joint efforts of specialists and their family doctors. Useful advice from family doctors reduces the need for patients to devote time and resources to specialist care to that which is necessary and essential.
  - Patients who cannot afford the fees of public services are subsidized to varying degrees, according to their financial situation.
  - Workload in public hospitals and clinics is less heavy for our young health care professionals whilst providing them with sufficient opportunities for training. There is a healthy turnover of staff in both the public and private sectors.”

## ***Chapter 1 - Introduction***

1.1 The Chief Executive announced in the 2005 Policy Address that the advisory framework for health care services would be reformed to facilitate the tendering of advice to the Government on long-term health care policies and financial viability.

### ***Reconstitution of the Health and Medical Development Advisory Committee***

1.2 Pursuant to the above, the Health and Medical Development Advisory Committee (HMDAC), chaired by the Secretary for Health, Welfare and Food, Dr York Chow, and comprising 13 members (membership at Annex A), was reconstituted on 1 March and was tasked to review and develop the service model for health care in both the public and private sectors; and propose long-term health care financing options.

1.3 At its first meeting on 4 March 2005, the HMDAC agreed to review the existing health care delivery system to see how it could be improved to cope with future needs and demands. The Committee would then, as a second step, deliberate on health care financing issues.

1.4 Against this background, three working groups on primary care, secondary care, and tertiary and specialized care were formed under the HMDAC to review and develop the future service delivery model for the respective areas. The membership list of the three working groups is at Annex B.

1.5 The services reviewed by the three working groups are western medicine services. The HMDAC recognizes the contributions of traditional Chinese medicine to Hong Kong, but as the development of traditional Chinese medicine and western medicine services are facing different challenges and opportunities, the Committee has decided to review the former in a separate exercise.

*This discussion paper*

1.6 This discussion paper of the HMDAC seeks to set out its views on the future service delivery model for Hong Kong's health care system with a view to building a sustainable system that is accessible and affordable by every member of the community.

*Future studies*

1.7 The HMDAC will proceed to its second phase of work on financing issues later this year. The target is to put forth recommendations on health care financing options by end of 2005 or early 2006.

1.8 Thereafter, the HMDAC will also embark on other service areas, namely mental health service, dental service and the development of Chinese medicine in Hong Kong.

## ***Chapter 2 - Need for Change***

### *Current situation*

2.1 Over the years, we have developed in Hong Kong an enviable health care system which provides accessible and quality health care to our citizens. Our health indices compare favorably with most developed countries. In 2004, the life expectancy at birth was 78.6 for men and 84.6 for women (Figure 1), which ranked respectively first and second in the world. We continue to enjoy high standards of medical service despite a narrow tax base (Figure 2) and low tax rate. However, these services do not come cheap. Our public health care expenditure has been increasing at an alarming rate. In 2004-05, the expenditure on health care services totaled \$30.2 billion and constituted 14.4% of the recurrent public expenditure. If we express this amount as a proportion of revenue from tax, of every \$100 received from tax, about \$22 is spent on public health care – a ratio which is among the highest in developed economies. One of the main reasons is that our heavily subsidised public health care services take care of most of the more expensive hospital services vis-à-vis the private sector.

Figure 1: Life expectancy at birth (2002)

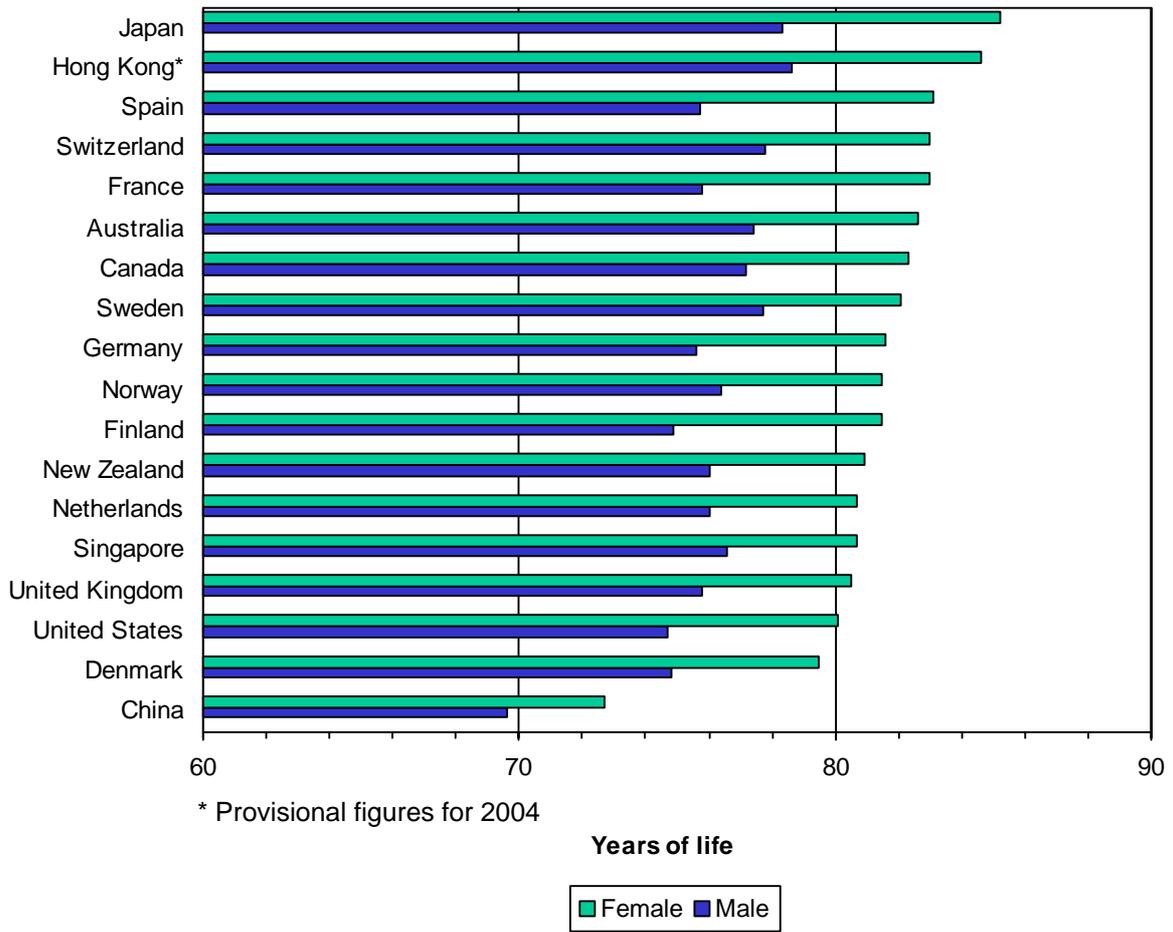
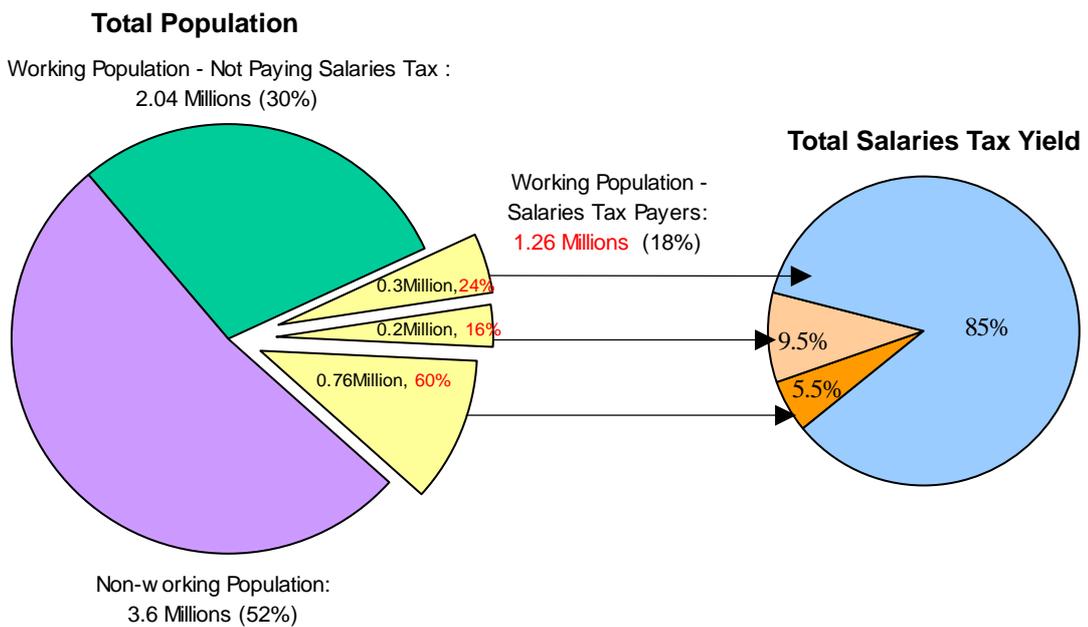


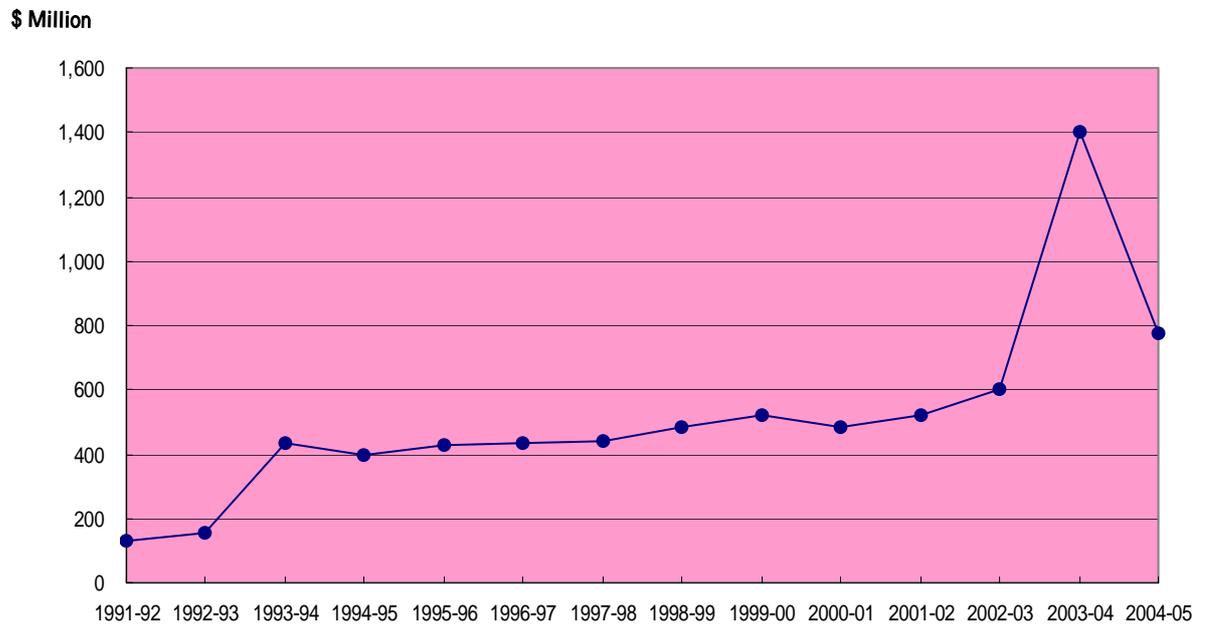
Figure 2: Salaries tax yield (2004/05)



## *The Hospital Authority as the main service provider*

2.2 Public health care services in Hong Kong are delivered mainly by the Hospital Authority (HA) set up in 1990. The HA currently operates 41 public hospitals and 15 public Accident and Emergency (A & E) departments which recorded some 2.1 million attendances in 2004-05. It also operates 74 general out-patient clinics with 5.3 million attendances in 2004-05 and 45 specialist out-patient clinics with 6.0 million attendances. In dealing with a caseload of this size, HA's expenditure doubled in 10 years' time - from \$14.5 billion in 1994-95 to \$27.8 billion in 2004-05 (Figures 3 & 4). This increase should, of course, be seen in the context of population increase, advancement in medical technology and improvement in the quality of HA's services. The question, nevertheless, remains whether the community should continue to put a larger and larger proportion of public expenditure on health care, and leave less and less for other services and infrastructure development.

Figure 3a: Non-recurrent subvention to the Hospital Authority (1991/92 – 2004/05)



Note : Additional provisions of \$600.4 million and \$63.4 million were made to HA under the "Commitment for the fight against SARS" in 2003-04 and 2004-05 respectively.

Figure 3b: Recurrent subvention to the Hospital Authority (1991/92 – 2004/05)

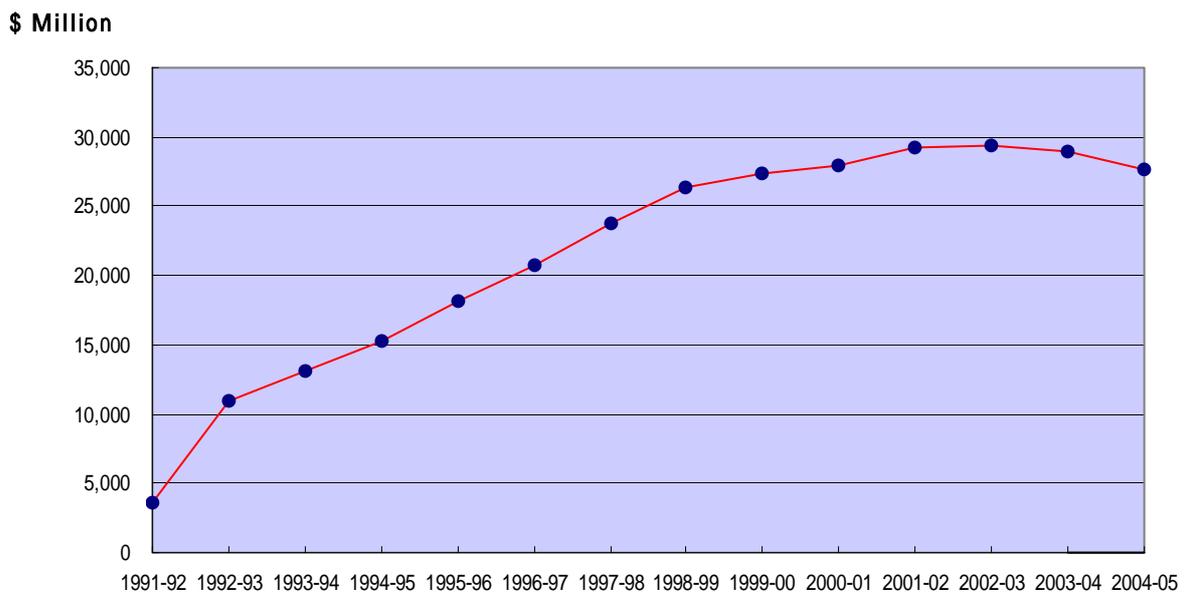


Figure 4: List of large-scale capital works projects

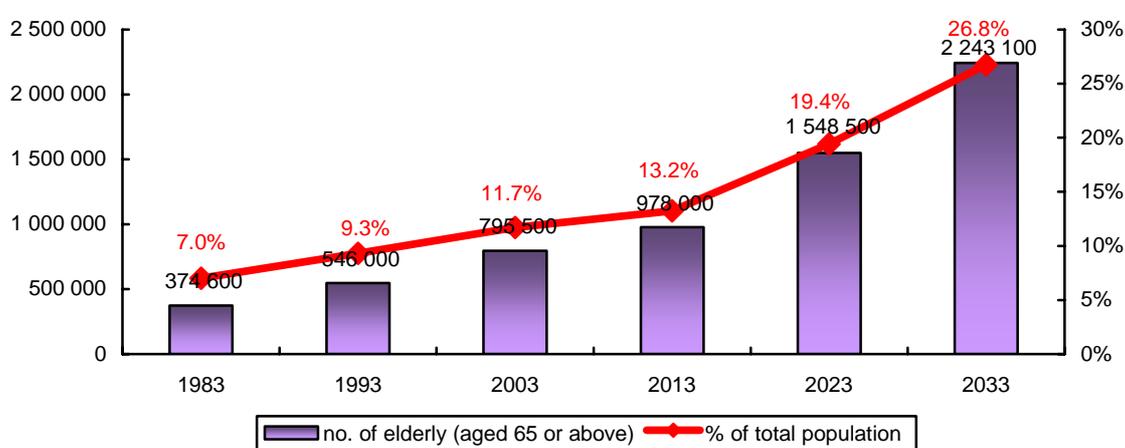
The total amount of government funding approved for HA's capital works projects from 1991-92 to 2005-06 is **\$24 billion**. A list of the large-scale projects (with approved project estimate over \$600 million each) is as follows:

<b>Project Title</b>	<b>Approved Project Estimate (\$M)</b>
Princess Margaret Hospital – Extension and Improvement Works	652.0
Construction of Tai Po Hospital	645.0
North District Hospital – Construction Works	1,690.4
Tseung Kwan O Hospital – Construction Works	2,047.3
Redevelopment of the Operating Theatre Block and the Rehabilitation Block in Queen Elizabeth Hospital	671.3
Construction of Kowloon Medical Rehabilitation Centre	894.8
United Christian Hospital Extension	604.9
Redevelopment of the Caritas Medical Centre	769.2
Construction of Princess Margaret Hospital Lai King Building	686.4
Kowloon Hospital – Phase 1 Redevelopment	1,083.3
Tuen Mun Hospital – Relocation of Tuen Mun Polyclinic	634.2
Redevelopment of Castle Peak Hospital, Phase 2	1,470.8
Redevelopment and Expansion of Pok Oi Hospital	1,666.1
Redevelopment of Staff Quarters for the Establishment of a Rehabilitation Block at Tuen Mun Hospital	1,031.4

## Challenges ahead

2.3 Looking ahead, with an ageing population (Figure 5), increasing medical costs and community expectations, our public health care system is reaching its limits. Its sustainability has been a cause of concern for the Government and the community. It is doubtful if the system, as it is, would be able to meet the future needs and aspirations of the community.

Figure 5: Elderly population in Hong Kong (1983 – 2033)



2.4 Specifically, challenges faced by the present system include -

- (i) an over-reliance on the public healthcare system which is heavily subsidized, with resources in the private sector under-utilized;
- (ii) an ageing population - 1 in 5 being over 65 by 2023 - meaning that the health bill and hospital service demand will increase exponentially;<sup>1</sup>
- (iii) tendency of early occurrence of chronic illnesses in the population resulting in prolonged reliance on the public medical

<sup>1</sup> Prevalence of chronic diseases in people aged 65 and above is more than five times higher than that of individuals aged 20. The patient days used by people aged 65 and above is 46% of the total. See Figures 6 and 7.

system;

- (iv) advancement in medical technology leading to increasing number of treatable medical conditions and expensive medications and technology; and
- (v) over-stretched hospital services, including specialist out-patient service and A & E departments.

Figure 6: Prevalence rate of chronic diseases by age (2002)

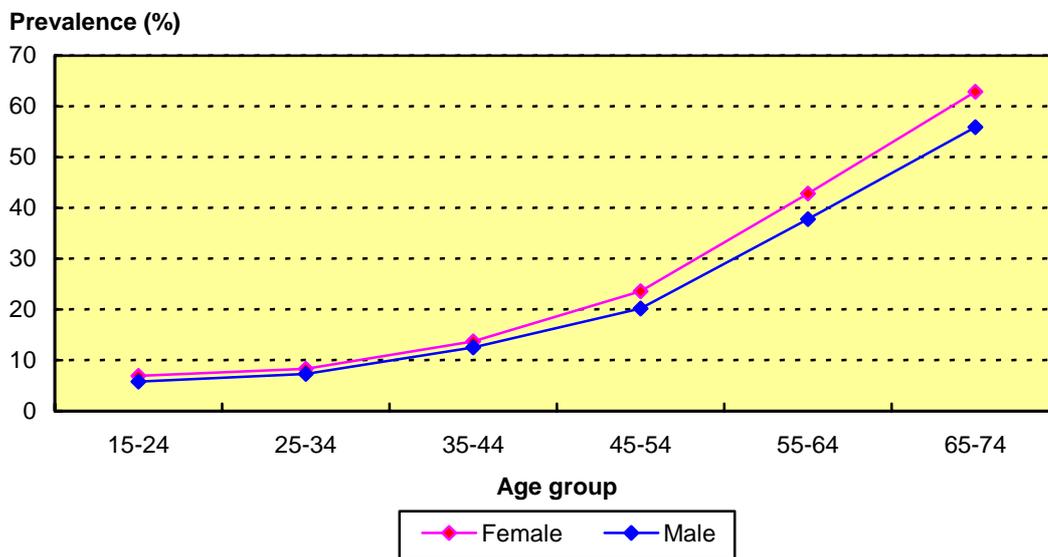
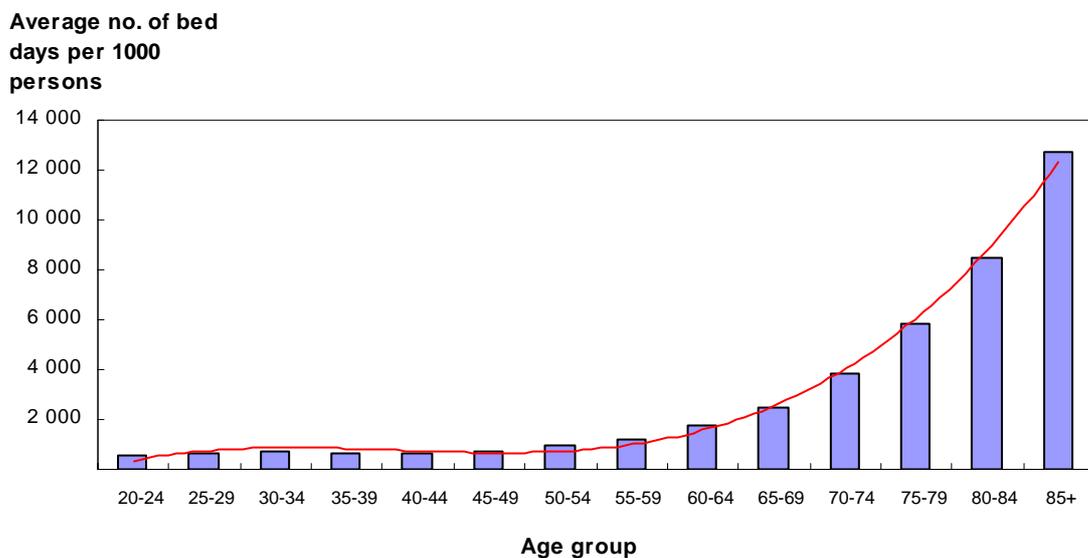


Figure 7: Average number of public hospital bed days by age (2002)



## *The price of inaction*

2.5 If we do not address the above situation and reform our service model, we project that the Government will have to spend well above \$50 on health care services out of every \$100 tax revenue collected by 2033 to provide the health care services currently provided. This will seriously impact on our other services, such as education, welfare and infrastructure developments. This is simply not an option.

2.6 Furthermore, all additional resources, if any, will be absorbed by the increasing demand as a result of the ageing population and the community's reliance on the public sector health care system. There will be no spare resources to improve on the existing system. As a result, waiting time for medical service will be even longer, public hospitals will be even more over-crowded and the overall service level will thus be downgraded. There will also be no spare resources to invest in preventive health care and rehabilitative service. The situation will become highly undesirable – not something we want.

2.7 A further consequence will be that, as the population rely heavily on the public health sector, the private medical workforce would shrink. The public medical workforce will, on the contrary, have to face an increasingly heavy workload with insufficient manpower. As a result, the community will have little choice but to revert to the public health care sector. This will end up in a vicious cycle. In time, there will not be sufficient incentives for young persons with good potentials to join the

health professions. The community as a whole will suffer.

### *Time for change*

2.8 We have good reasons to be proud of our present health care system and if we wish to continue to do so, we must meet the challenges outlined above. Our shared vision is to ensure that the community will continue to enjoy a high level of health care service which is sustainable, affordable and accessible to all. To this end, we should have a shared mission - to critically review and re-think what our future health care model should be so that our vision can be attained.

## ***Chapter 3 - Future Service Delivery Model***

3.1 For years, our culture puts emphasis on curative care – we visit our doctor only when sick. Most of us tend to overlook the importance of preventive care and continuity of care which are the fundamentals of effective management of our own health. Also, many people tend to believe that hospital care provides the best care for our illnesses and overlook the part that home and family care plays in many cases. These perceptions and culture affect the way our public health care services are utilized and hence the increasing demand for such services.

### *Future health care model*

3.2 In developing our future health care model, our aim is to ensure that our limited resources are being utilized in the most appropriate manner to achieve the best health outcome for those in genuine need of such service. We believe that our future health care model should contain the following elements –

- (i) A population which is knowledgeable about health and health risk factors, so that the general public can and will adopt a healthy lifestyle, and take responsibility for their own health.
- (ii) A health care profession that views health promotion and preventive medicine as priorities, and exercises its practice professionally and ethically.
- (iii) A primary health care system which can provide a robust family and community medicine service affordable by all, whilst

incorporating strong elements of health promotion and preventive care, with standards set for the care of different age groups and health status.

- (iv) A hospital service network which can provide emergency and secondary care within reasonable reach of the population in all districts, in order to enhance service access and family visitation.
- (v) Elderly, long-term and rehabilitation care services which encourage home care with community outreach and professional support, with infirmary and hospice care in all districts to enhance maintenance of family support.
- (vi) The establishment of specialized tertiary centres and hospitals to develop and concentrate expertise, technology, special facilities and research for the treatment of catastrophic illnesses.
- (vii) Well-integrated public and private sectors which promote healthy competition for service quality and professional standards, and provide a choice for the public.
- (viii) A financing model which encourages appropriate use of health care services, ethical and effective professional care, reasonable and affordable contributions by users, and with targeted subsidies through public funds for unfortunate patients and families in genuine need.

### *Positioning of the public and private sectors*

3.3 Our future health care model will involve, among others, a re-alignment of roles between the two main service providers of our health

care system, namely the public sector (HA and the Department of Health (DH)) and the private sector (private hospitals, private medical practitioners and other non-government entities). To ensure that our limited resources are being utilized in the most appropriate manner and for those in genuine need of such service, we believe that our public health care service sector should target its services at the following areas –

- acute and emergency care;
- for low income and under-privileged groups;
- illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and
- training of health care professionals;

whereas our private sector should be one that –

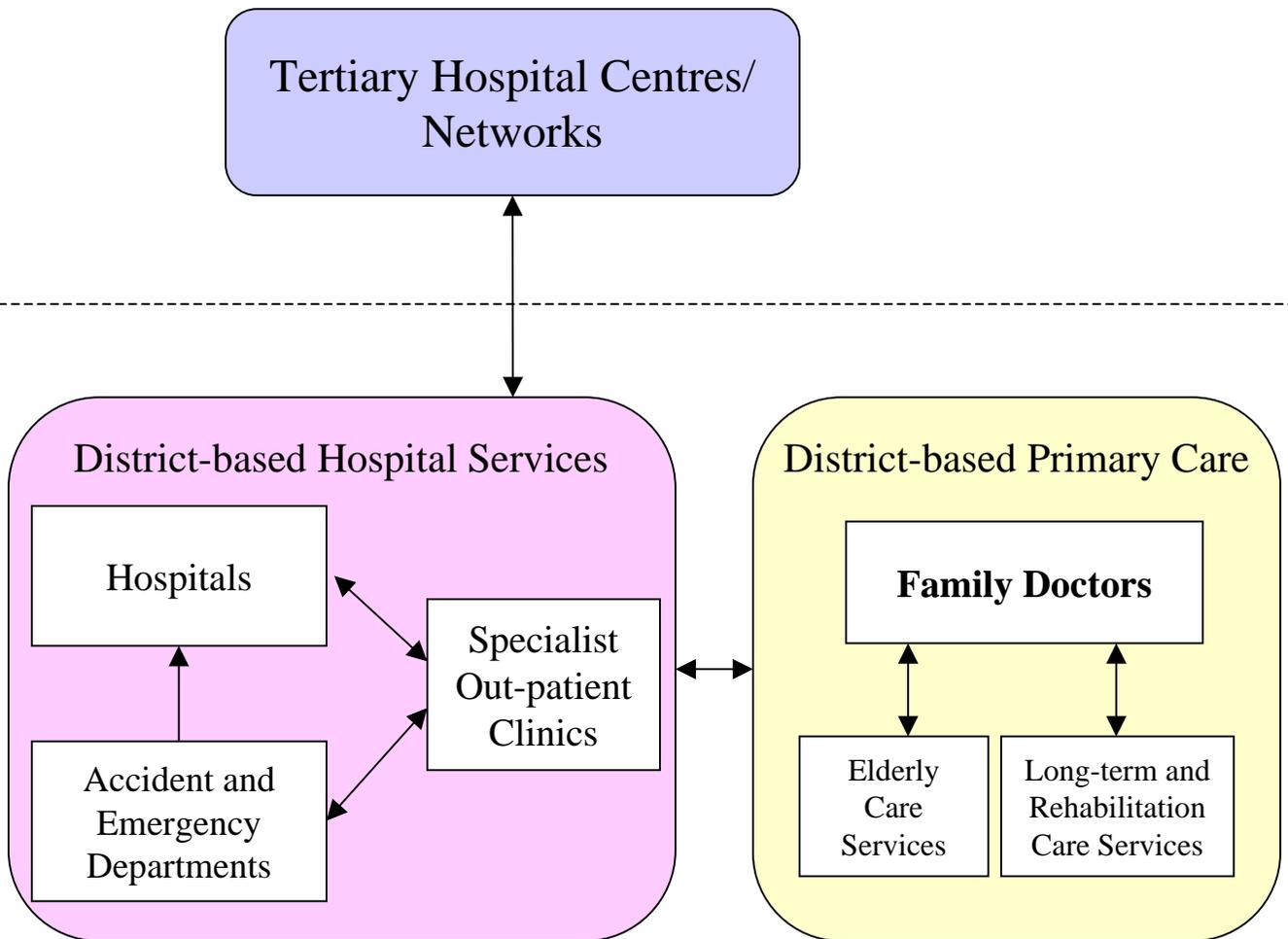
- provides comprehensive, personal and quality care to patients;
- provides choice for the community;
- is affordable by people of average income level;
- attracts young members of the health care professions; and
- contributes towards the training work for health care professionals.

### *Changing needs of the patient - different levels of care*

3.4 Health care is a continuing and developing process. Our future health care system should be capable of responding flexibly to the changing needs of the patient by providing him/her with the appropriate level of care – primary, secondary or tertiary - either through the private or public sector. To make the best use of resources, the system should encourage “smooth transition” of patients between different levels of care in response

to changing care needs. We believe that such a dynamic system will ensure that our limited resources are utilized to achieve the best health outcome.

# Future Health Care Delivery Model



## ***Chapter 4 - Primary Medical Care Services***

### **Future Model**

4.1 According to the World Health Organization's definition, primary health care is an integral part both of a country's health system and of the overall social and economic development of the community.<sup>1</sup> It involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, food industry, education, housing etc.; and demands the co-ordinated efforts of all those sectors. In this chapter and part of the next chapter of this discussion paper, we will be examining the medical aspect of primary health care including preventive, curative and rehabilitative services.

4.2 Primary medical care is the first point of contact individuals and the family have with a continuing health care process and constitutes the first level of a health care system. It is the base upon which the rest of the health care system is organized. Effective primary medical care services will be able to improve the health of the population as well as reduce pressure on the hospital system. Thus what we need is –

*A primary medical care system which can provide a robust family and community medicine service affordable by all whilst incorporating strong elements of health promotion and preventive care, with standards set for the care of different age groups and health status.*

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<sup>1</sup> Adapted from the opening statement in the Report of the International Conference on Primary Health Care Alma-Ata 1978. World Health Organization, Geneva.

## *What is the essence of primary medical care?*

4.3 Primary medical care is not just about the curing of episodic diseases. Primary medical care services should provide ***continuing, comprehensive and whole-person*** medical care to individuals in their home environment. We will discuss how the current primary medical care services are performing in terms of these three elements in the following section.

### **Present Phenomenon**

#### *(i) Importance of continuity of care not fully recognized*

4.4 A continuing relationship between the primary care doctor and the patient is essential in that the doctor is familiar with the patient's medical history, lifestyle and other factors that may affect his / her health and is able to recommend the best course of preventive action or treatment. Furthermore, only when there is a long-term doctor-patient relationship can the doctor give, and the patient be receptive to, appropriate education and counselling that will help the patient manage his / her own health problems. With a continuing relationship in place between the primary care doctor and the patient, much more can be done to provide more preventive care and whole-person care. However, Hong Kong's culture has all along emphasized quick cure of the patient's disease as most important, and it is a fairly common phenomenon that patients would consult another doctor for the same illness if the symptoms persist after taking the medication prescribed by the first doctor.

*(ii) More emphasis on prevention needed*

4.5 Apart from being able to provide appropriate treatment, comprehensive primary medical care should encompass a strong element of prevention and patient education and counselling. At present, the community is not sufficiently aware of the merit of and opportunities for receiving preventive services in primary medical care. Some preventive services such as vaccinations are often sought by patients from primary care doctors, but others like screening for risk factors, detection of early symptoms and signs of disease and assessments and corrections of health risks are not often given sufficient emphasis by both doctors and patients. This is partly due to the lack of continuity of care, and partly due to the over-emphasis on quick cure. We also note that there is insufficient emphasis on the importance of preventive care in public health education.

*(iii) Gate-keeping role / First-point-of-contact role needs strengthening*

4.6 Primary care doctors should be the first point of contact for patients in most circumstances, including in acute conditions and in cases when a decision is needed as to whether specialist care is required. Also, as gate-keepers of the hospital system, primary care doctors should assume the role of long-term carers of patients with chronic disease whose conditions have stabilized. At present, many patients do not perceive primary care doctors to be having this role. A large number of patients visit the A & E department of public hospitals direct should acute symptoms or illness occur and also for treatment of non-urgent illnesses. There is also a common misconception that specialist care is better than primary medical care such that patients tend to prefer specialist care

regardless of their conditions. Indeed, many patients, especially those who opt to use private specialist service, often seek specialist care services themselves, without first consulting a primary care doctor.

4.7 Using the primary care doctor as the first point of contact will not only enable the patient to act most appropriately based on sound medical advice, but also prevent unnecessary investigations and treatment, and ensure that resources of both the patient and the hospital system are used most appropriately. Our patients and health care system have so far not been able to derive maximum benefit from primary medical care services in this respect.

*(iv) More collaboration with other professionals required*

4.8 Whole-person care requires comprehensive and thorough understanding of the patient's problems that affect his / her health and deriving solutions that resolve these problems. In Hong Kong, the emphasis of primary medical care is often put on treatment of episodic diseases. Problems beyond the patient's physical condition which nevertheless affect his long-term health status, e.g. occupational hazards, family problems, psychological problems, are seldom dealt with fully. If there was more collaboration between health care professionals and other professionals, e.g. social workers, psychologists, therapists, in the investigation and resolution of the patient's overall problems, better results would be achieved.

## **Consequences**

### *Room for improving population health outcome*

4.9 The combined effect of insufficient continuity of care, comprehensiveness and whole-person care is that we have not been able to achieve the best health outcome for our population. The incidences of chronic illnesses and their complications have been increasing, and there is an increased tendency of early occurrence of chronic illnesses, resulting in poor quality of life for patients and prolonged reliance on the medical system. The under-utilization of primary care doctors as the gate-keeper of the hospital system often results in wasting of time and resources to repeat investigations in the hospital setting to find out basic information about the patient. It also results in a more expensive health bill for the patient and the community as a whole.

## **Recommendation**

4.10 We recommend promoting the family doctor concept which emphasises continuity of care. We also recommend primary care doctors to place greater emphasis on preventive care and raising the public's awareness to the importance of prevention. The Government should also encourage and facilitate medical professionals to collaborate with other professionals to tackle their patients' problems.

## **Moving Towards the Future Model**

### *Promoting the family doctor concept*

4.11 Since continuity of care is imperative to improving the quality of primary medical care, we recommend the Government and the medical profession to promote the concept of family doctor. A family doctor can be a general practitioner, a family medicine specialist, or any other specialist. The important point is for the patient to have a continuing relationship with the doctor of his / her choice, and that the doctor has the mindset and training of managing problems at the primary care level in a holistic way. The family doctor should be the one to whom the patient turns in most circumstances when in need of medical assistance or advice, and, because of the long-term relationship that has been built up, is the one most familiar with his / her medical history, lifestyle, habits and other factors that affect his / her health. While it is desirable for the whole family to be cared for by the same family doctor, this is not always necessary.

4.12 We recommend the Government to devote more public education efforts to promote this concept not only to the public, but also to primary care doctors. On their part, primary care doctors will have to be prepared to expand their current modes of operation to enhance trust amongst patients. For example, family doctors may have to offer medical advice or even consultations beyond normal clinic-opening hours, conduct more investigations and screening tests to act as an effective link between the patient and the specialist, and incorporate a larger element of preventive

care in their consultation sessions.

*Provision of information by government to improve preventive care*

4.13 To enable family doctors to provide effective preventive care to patients, we recommend the Government to enhance the identification and assessment of the impact of social and environmental variables on health and the communication of this information to family doctors. The Government should also launch more public education on prevention of diseases and illnesses.

*Establishment of a platform on a regional / district basis to facilitate collaboration among medical and other professionals*

4.14 To improve collaboration between family doctors and other professionals, we recommend the Government to draw together family doctors in private practice, primary care doctors of the public medical sector and other professionals working in each region / district and provide a platform for them to share observations, exchange information and alert and refer cases to each other with a view to taking care of the population's needs from all possible angles. The professionals to be involved can include social workers from the Social Welfare Department and NGOs (who may be in a better position to tackle family and psychological problems which may have a bearing on health), Health Inspectors from the Food and Environmental Hygiene Department (who may be required to tackle health problems of patients arising from environmental hygiene) and others. We note that there are already existing district channels involving

the welfare and medical sectors for dealing with welfare-oriented issues such as domestic violence. The Government may build on this basis or take reference from this arrangement to involve more professionals to tackle patients' problems.

*Purchasing primary medical care service from the private sector*

4.15 We also recommend the Government and HA to consider providing part of its primary medical care service through purchasing such service from the private sector with the objective of improving the quality of primary medical care. Through engaging family doctors in the private sector to provide service, the Government can –

- set requirements on the qualifications and continuing medical education of the doctors concerned;
- ensure effective gate-keeping for public hospitals by requiring adherence to referral protocols;
- require desirable practices to be adopted, e.g. provision of medical records to patients;
- require prescribed preventive services to be provided for relevant age groups;
- audit the clinical practice of the doctors concerned to monitor the standard of service.

4.16 The standard required of family doctors from whom the Government purchases service will gradually become a benchmark for primary medical care in Hong Kong. As a next step, the Government

may consider developing standards of care, including preventive care, for different age groups and different patient groups for reference by family doctors.

#### *Development of the private sector in primary medical care*

4.17 The Government and the private sector should work hand-in-hand to provide better service to patients. In addition to changing the mode of operation as mentioned in paragraph 4.12, we recommend the private sector to take actions to enhance confidence amongst patients, such as pursuance of continuous medical education and devoting more time to educate patients to manage their own health problems.

4.18 Furthermore, we recommend private sector family doctors in private practice to consider working together in group practice. While solo practice has certain advantages such as greater flexibility in operation, group practice offers the advantages of reduced overhead costs, enabling the sharing of resources and equipment and providing coverage for leave-taking. All these are conducive to improving the quality of service to patients. More importantly, doctors in group practice will influence each other's clinical behaviour and thus promote sharing of desirable practices.

#### *The community to change old perceptions*

4.19 The community will also have to change their understanding and raise their expectation of what primary medical care can offer to derive

maximum benefit from this level of care. To gain real improvements for their health, patients should recognize the importance of continuity of care. The community should also recognize the importance of disease prevention and a healthy lifestyle to improve the population health and quality of life.

*Family doctor as first point of contact for patients*

4.20 The question of how to channel patients to use the service of the family doctor as the first point of contact for acute conditions, as a link with the specialist and as the long-term carer in case they have stable chronic disease will be discussed in the next chapter. We will deliberate in the next chapter the problems created by over-use of specialist services in the public hospital system and under-use of primary medical care services in the community.

## ***Chapter 5 - Hospital Services***

### **Future Model**

5.1 Hospital care is part of the continuum of care in the health care system, with the role of providing short-term and more specialised care for acute and complicated medical conditions. We envisage a future hospital care model comprising –

*A hospital service network which can provide emergency and secondary care within reasonable reach of the population in all districts, to complement and support primary care services, and enhance timely service access for patients with genuine need for hospital care and facilitate family visitation.*

5.2 In this chapter, we will first review the current provision of hospital services against the future delivery model. We will also review the current patterns of hospital services utilisation and put forth recommendations on how we could move towards our future model set out above.

### **Review of Hospital Services Provision**

5.3 At present, there are 41 public hospitals providing a total of 20 550 general hospital beds and 7 681 illness-specific beds (for psychiatric, mentally handicapped and infirmary patients). Fourteen of the public hospitals are major acute hospitals providing emergency and other hospital

services. The majority of their hospital admissions are through A & E departments. There are also 12 private hospitals with a total of 2 794 beds, but they are mostly equipped with 24-hour out-patient clinics and none of them has A & E departments.

### *Acute and non-acute hospitals*

5.4 There is an average of 3.4 (public and private) acute and convalescent hospital beds per 1 000 population in Hong Kong. The 14 acute hospitals are strategically located in densely populated districts (Figures 8 & 9), underscored by the fact that Hong Kong is very compact and urbanised, with an efficient transportation network and high-performance ambulance service. Under the cluster structure in HA, all the acute hospitals are supported by smaller-sized non-acute hospitals in each cluster.

Figure 8: Distribution of acute public hospitals with accident and emergency services in different clusters of the Hospital Authority

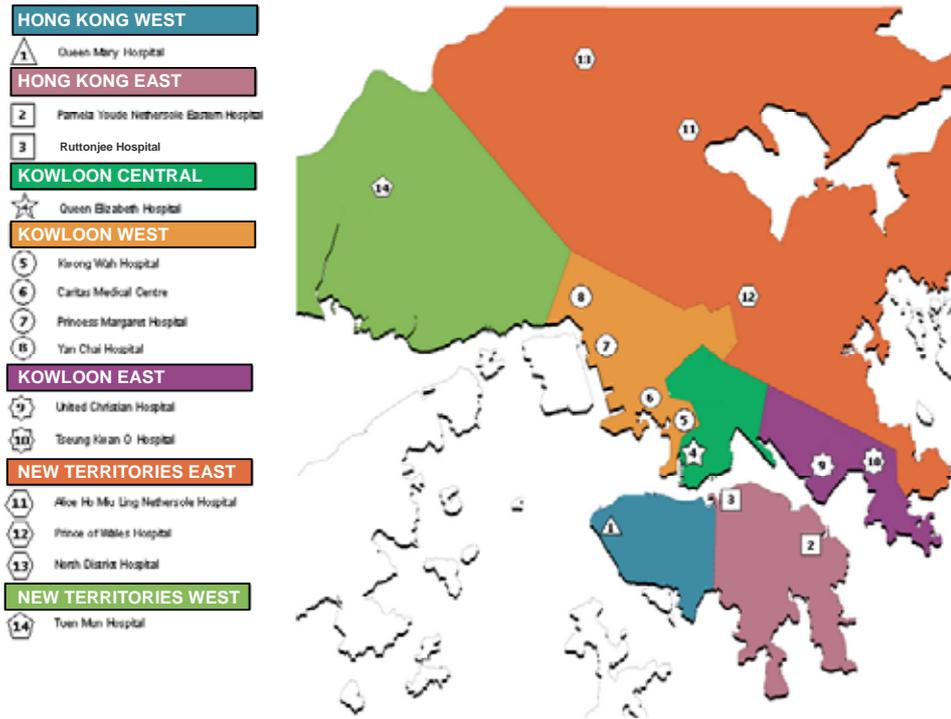
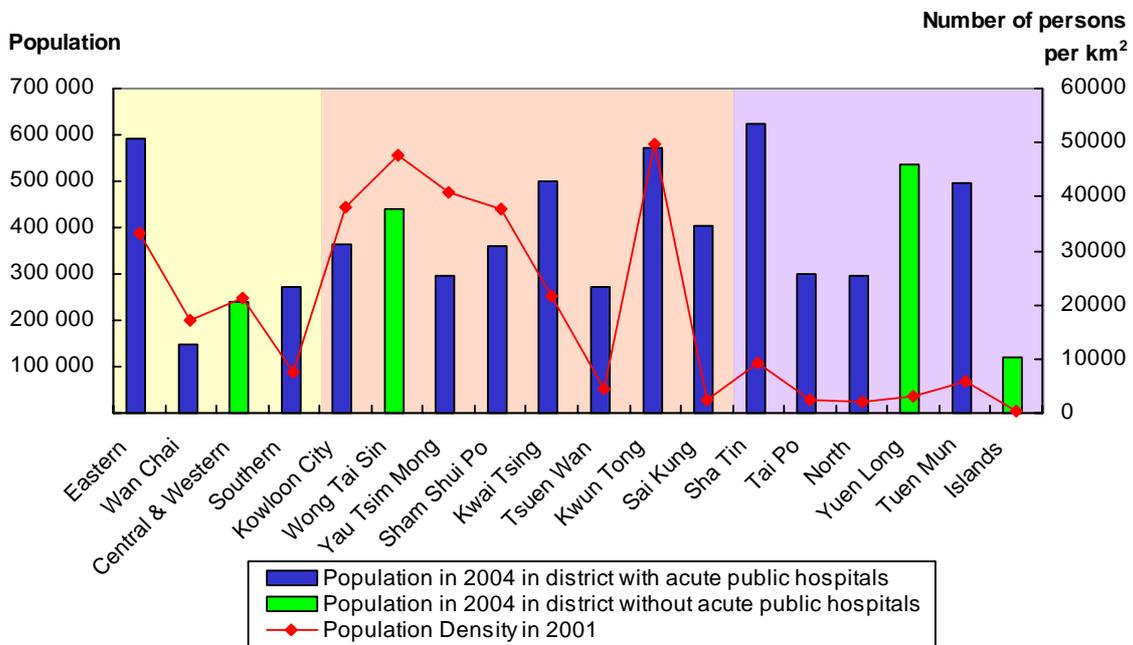


Figure 9: Distribution of acute public hospitals with accident and emergency services by district (2004)



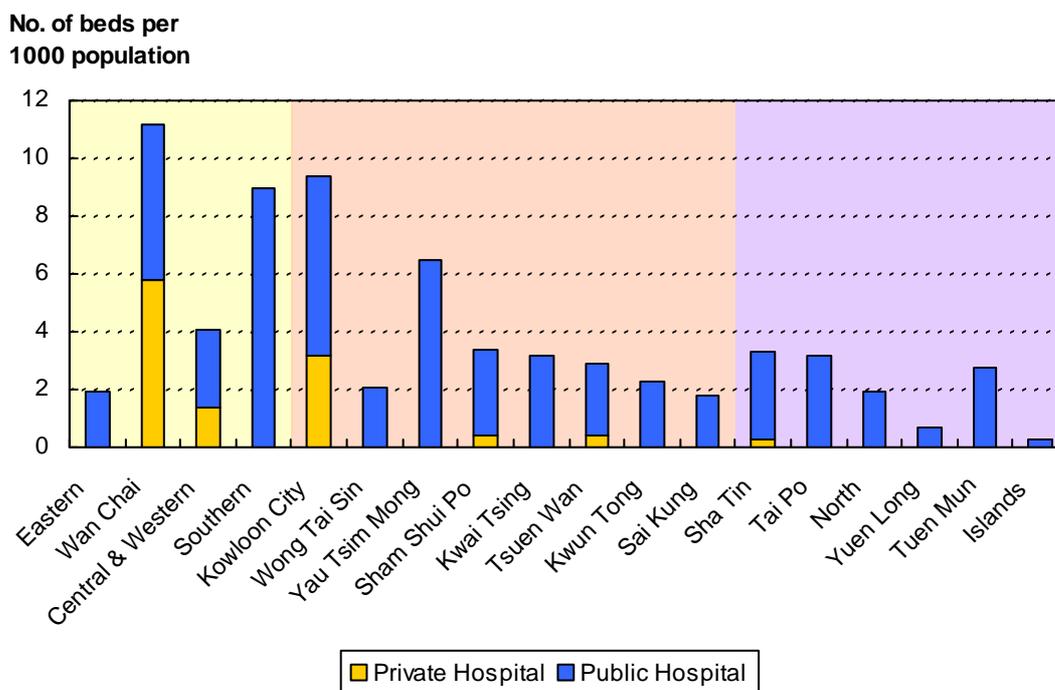
**Notes:**

The 18 districts are demarcated as situated in the Hong Kong Island, Kowloon and New Territories regions according to the **Cluster demarcation used by the Hospital Authority (HA)**, which is slightly different from that used by the Home Affairs Department (HAD) for district administration purpose. For example, Kwai Tsing and Tsuen Wan Districts are served by HA's Kowloon West Cluster and Sai Kung District is served by the Kowloon East Cluster while for HAD, they are considered as New Territories districts.

## Accessibility

5.5 In terms of accessibility, the present public hospital networks are able to meet the requirement of ensuring emergency and secondary care to be within reasonable reach of the population in all districts. However, the number of A & E attendances and proportions of truly emergency cases vary among different acute hospitals. Furthermore, acute and convalescent bed provision ranges from under 1 to over 10 per 1 000 population (Figure 10) in various districts. This is due to the fact that the current locations, size and nature (acute or non-acute) of hospitals are partly an outcome of historical development rather than that of planning according to a critical mass of demand worked out with regard to the characteristics of individual districts or communities.

Figure 10: Acute and convalescent bed supply by district (2004)



5.6 Most of the acute public hospitals currently provide a comprehensive range of specialty services. However, while our citizens have demonstrated high demands for services in core specialties such as Medicine, Orthopaedics and Surgery, service volumes of some other specialties currently being provided in some acute public hospitals are not high. Since Hong Kong is a small and densely populated area, there is room for rationalisation of the current spread of low-volume specialties to enhance the efficiency of public hospitals.

### **Recommendation**

5.7 For hospital service networks to effectively complement and support primary medical care services, and provide emergency and secondary care within reasonable reach, we recommend that future acute hospitals be planned on a district / regional basis, taking into consideration population characteristics and other relevant factors. The specialties to be provided in an acute hospital should be determined by the needs and demands of each district. To achieve further economies of scale, specialties serving small number of patients should be provided in the form of networks comprising several hospitals.

### **Moving Towards the Future Model**

5.8 The current planning standard for hospital beds is 5.5 beds (including all types of hospital beds and beds in both the public and private sectors) per 1 000 population. However, due to recent advances in medical technology and knowledge about the process of rehabilitation,

bed-day savings are already being realised in public acute and non-acute hospitals. This planning standard has thus become too rigid. In the future planning of hospital bed provision in individual districts, we recommend that the following factors be taken into consideration –

- population size;
- expected changes in population demographics, in particular the elderly population;
- possible over-provision or under-provision of hospital beds in the same and neighbouring districts and utilisation patterns of various age-groups and gender, especially that of the elderly;
- income distribution in the district, including the proportion of Comprehensive Social Security Assistance (CSSA) recipients;
- advances in medical technology; and
- availability of private hospital beds in the district and their utilisation.

5.9 For *acute hospitals*, as in line with current practice, we recommend that they should be equipped with the basic infrastructure of A & E departments with support from selected specialties on-site and access to other specialties based on networks. Since the number of A & E attendances and proportions of genuinely emergency cases vary among acute hospitals and are particularly low in some, we recommend HA to review the critical mass of demand by A & E departments to identify the need for merging or other forms of rationalisation, in order to ensure an optimal provision of A & E services for all districts.

5.10 For *supporting specialties*, we recommend that all acute hospitals should be provided with core specialties on-site. These core specialties should be those used by large number of patients and with high proportions of A & E admissions. At present these include Medicine, Orthopaedics and Surgery. For other specialties, we note that HA has already formed networks to provide services. For example, Paediatric services are currently offered in 12 acute hospitals, Gynaecology in 11 and Neurosurgery in eight. We recommend HA to monitor the numbers of A & E admissions in these specialties, and identify room for further service rationalisation to achieve further economies of scales and improvements in efficiency.

5.11 In order that catastrophic events are managed effectively and efficiently, we recommend the public hospital sector to clearly identify several district-based hospitals to be equipped with enhanced accident and emergency capabilities in their A & E departments. To deliver complex emergency care, these hospitals should be equipped with a comprehensive range of specialty services and higher levels of intensive care facilities. We note that the HA has already designated five acute hospitals as trauma centres. Further designation of specialised emergency centres along this direction should be pursued.

5.12 We also encourage public hospitals to continue to develop and adopt advanced technology which will bring about a reduction in the length of hospital stay (in particular through the provision of ambulatory care) and

thus more efficient use of resources. The public hospital sector should also look for opportunities to co-ordinate the planning and development of ambulatory services with private hospitals so that resources in the two sectors can be maximised. If resources in private hospitals can be used more fully, there will be a consequent cost reduction in the private sector. This would provide patients with more choices and help redress the current imbalance between the two sectors.

### *Current patterns of hospital services utilisation*

#### **Present Phenomenon (i) and Consequences**

##### *(i) Inappropriate use of hospital services and under-utilisation of primary medical care services*

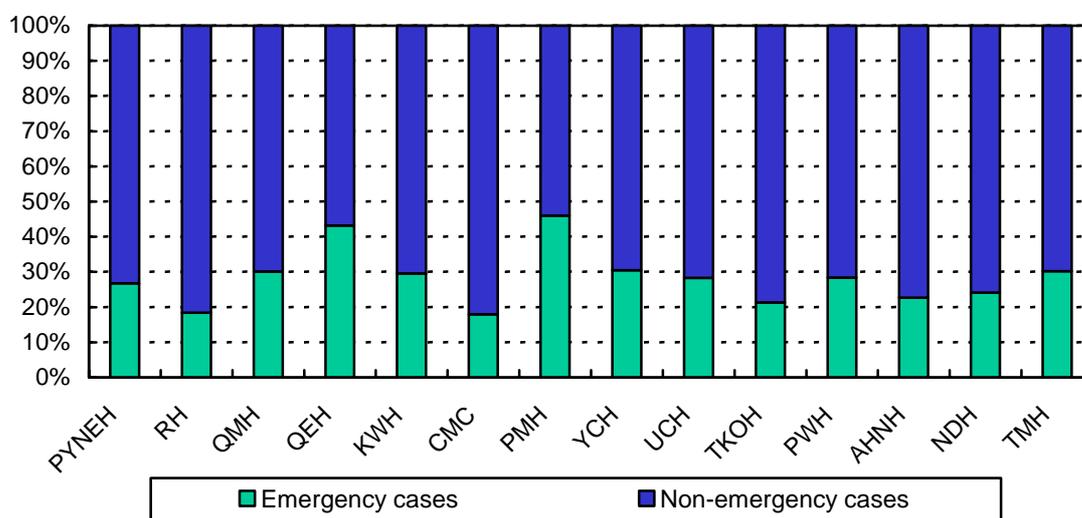
5.13 Hospital services can be broadly classified into three categories – A & E service, specialist out-patient (SOP) service and in-patient service. The current review shows that there is considerable inappropriate utilisation of the first two types of services. A large number of patients using A & E and SOP services do not actually need such services.

##### *Accident and Emergency (A & E) service*

5.14 Although A & E service is designed to meet the needs of patients with emergency conditions, about 70% of patients attending A & E departments of public hospitals in 2004 were suffering from non-emergency conditions (Figure 11). While it is understandable that many patients are not able to determine whether their acute conditions require emergency or non-emergency care, it is also true that others simply

utilise A & E departments as a convenient alternative to out-patient clinics, in particular outside normal consultation-hours of clinics. This health service seeking behaviour is very different from that in many developed countries, in which the family doctor is the first point of contact for most illnesses, including acute ones, and it is the family doctor who decides whether or not emergency hospital service is required at each presentation.

Figure 11: Proportion of emergency and non-emergency cases at individual acute public hospitals (2004)



**Notes:**

PYNEH – Pamela Youde Nethersole Eastern Hospital  
 RH – Ruttonjee Hospital  
 QMH – Queen Mary Hospital  
 QEH – Queen Elizabeth Hospital  
 KWH – Kwong Wah Hospital  
 CMC – Caritas Medical Centre  
 PMH – Princess Margaret Hospital

YCH – Yan Chai Hospital  
 UCH – United Christian Hospital  
 TKOH – Tseung Kwan O Hospital  
 PWH – Prince of Wales Hospital  
 AHNH – Alice Ho Miu Ling Nethersole Hospital  
 NDH – North District Hospital  
 TMH – Tuen Mun Hospital

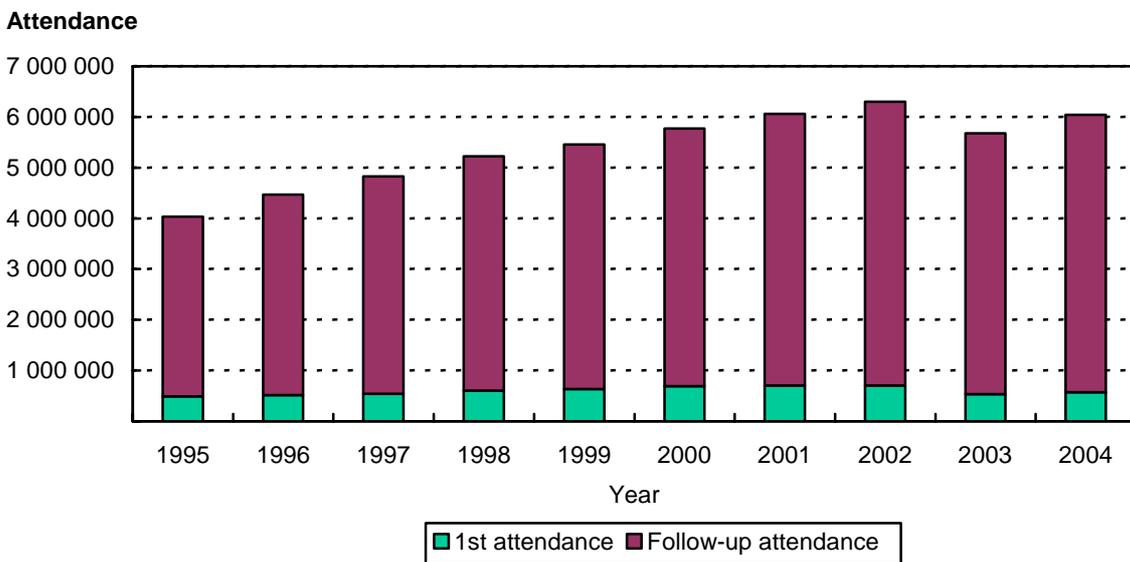
5.15 Since A & E department is designed to deliver emergency medical services, problems arise when resources are over-stretched to attend to a large number of patients with non-emergency conditions. First and foremost, frontline staff are overworked. This affects the efficiency of care for patients with genuine emergency conditions. Secondly, long waiting time for patients with non-emergency conditions becomes inevitable, resulting in patient complaints and conflict with frontline staff, which in turn lead to further demoralisation of staff. Finally, family doctors, who are in the best position to determine whether or not their patients have emergency conditions and to effectively manage non-emergency cases, are under-utilised.

#### *Specialist out-patient service*

5.16 As for SOP service, there has been a 50% increase in the number of attendances at public specialist out-patient departments (SOPDs) in the past 10 years (Figure 12). This is to a large extent attributable to an accumulation of “old” patients, some of whom have been followed-up at SOPD for years even though their medical conditions have long been stabilised and no longer require specialist care. Factors contributing to this phenomenon include: firstly, patients in general have more confidence in specialists than primary care doctors regardless of the nature or severity of their medical conditions; and secondly, patients requiring long-term medication prefer to stay within the SOPD system where the drugs are highly subsidised. When stabilised cases are not discharged back to the primary care doctors, there is a steep growth in the number of cases in the

SOPD of public hospitals. The waiting time for and the waiting list of newly referred patients are becoming increasingly long. This compromises the efficiency of care for patients who have genuine need for SOPD services.

Figure 12: Total number of attendances at specialist out-patient clinics of public hospitals (1995 – 2004)



5.17 Family doctors are again in the best position to provide long-term medical care to these stabilised patients with uncomplicated chronic illnesses, and would contribute greatly to improving the efficiency of SOPD in public hospitals. Compared with their counterparts in developed countries, however, family doctors in Hong Kong are often not viewed by patients as carers with the capability of managing uncomplicated chronic illnesses, such that their services are frequently grossly under-utilised.

## **Recommendation**

5.18 Resources in public hospitals are limited. To manage escalating demand and enhance access to timely service for patients with genuine need for hospital care, we recommend that clearly defined indications for the use of public hospital resources should be promulgated. In particular, an explicit policy should be made to facilitate public hospitals to perform their rightful role of providing short-term and specialised care for complicated medical conditions. In this regard, family doctors should play a more prominent role as “gatekeepers” of the hospital system. By acting as the first point of contact in acute and other conditions and providing continuity of care to medically stable patients with long-term medical care needs, family doctors could contribute greatly to reducing the pressure on the more expensive and technologically more specialised hospital services, thus allowing time for the hospital system to care for patients with genuine needs.

## **Moving Towards the Future Model**

5.19 We recommend the Government to promote the better use of family doctors’ services as the first point of contact for illnesses, including acute but non-emergency cases, and to provide continuity of care, especially in the long-term medical care of chronic patients. The Government should also review the fees and charges of A & E service, SOPD service and drug supply of public hospitals, such that hospital services will not cost significantly less compared to a family doctor’s

service. This step is essential towards minimising the unnecessary attraction for patients to utilise public hospital services even though their conditions could be more appropriately and effectively managed by family doctors. More specific measures that should be taken in respect of patients with acute but non-emergency conditions and chronic but medically stable patients are discussed in the following paragraphs.

*Patients with acute but non-emergency conditions*

5.20 For these patients, there must be sufficient alternatives to A & E services if they are to change their behaviour. The community will need more primary care doctors who are willing to establish long-standing relations with patients and be a true recourse in need, as well as provide round-the-clock clinic service. We recommend primary care doctors to inspire reliance and trust amongst patients by, inter alia, making arrangements to enable patients to seek advice from them when needed, e.g. by providing their patients with outside-consultation-hour contact telephone numbers.

5.21 We note that the number of 24-hour medical clinics, including 24-hour out-patient departments of 11 (out of a total of 12) private hospitals, are not sufficient and are centred in some districts while other districts are without such clinics. To fill this gap, we recommend that the private medical sector should be encouraged to establish more 24-hour clinics.

5.22 We appreciate that patients would be worried about the

consequences of a seemingly non-emergency condition turning out to be an emergency one, and that consulting their family doctors or visiting 24-hour clinics may delay treatment. To address this concern, we recommend that A & E departments of public hospitals to take the initiative to –

- share with family doctors and 24-hour clinics in their districts their triage criteria and waiting time for different triage categories, and
- establish links and protocols with family doctors and 24-hour clinics in their districts, such that consultation and transfer of patients with real emergency conditions identified in 24-hour clinics or by family doctors are expedited, with minimal waiting time before being attended to by A & E specialists on arrival in an A & E department.

5.23 We recommend the private sector to consider how best to provide 24-hour clinic services. As a first step, family doctors in solo practice within a district may collaborate to take turns to provide service beyond normal clinic opening hours. 24-hour clinics may also consider strengthening their manpower resources with clinicians in the private sector who had undergone A & E training and their clinic set-up with simple diagnostic facilities. We recommend that private hospitals may also consider developing formal A & E service.

#### *Chronic patients who are medically stable*

5.24 For these patients, we recommend public hospitals to make it an explicit policy to refer them back to their family doctors or their referring

doctors in public or private primary care services. We recommend public hospitals to take the lead in establishing referral protocols and shared-care programmes with primary care doctors. By doing so patients can be reassured that, under appropriate conditions, (such as when their conditions deteriorate or when complicated acute medical conditions develop), they will be assured of access to specialist care again.

5.25 We recommend the private sector to take an active part in jointly establishing with the public sector referral protocols and shared-care programmes, and to adhere to these protocols and programmes as far as possible after implementation. Referrals to SOPDs should be accompanied by patient record and relevant investigation results as specified in the agreed referral protocols. This will save time and resources for SOPDs to conduct further investigations in order to collate basic information about referred patients.

5.26 For this model to be successfully implemented, we recommend that the community needs to change some entrenched perceptions, such as seeing A & E departments as the only resort after normal clinic-opening hours, and seeing specialists care as being always better than primary care. Family doctors will only be able to contribute their best of what they can if patients are willing to make use of their services.

5.27 The successful diversion of suitable patients currently utilising hospital services to primary care doctors will release corresponding resources to improve hospital services. We recommend that these

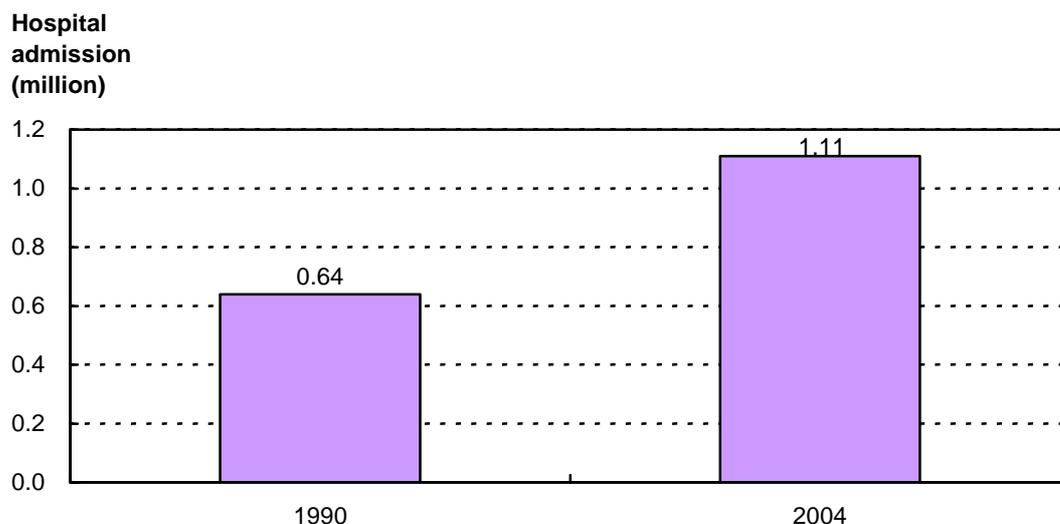
resources be ploughed back to the respective services to effect improvements to patient care, e.g. to reduce waiting time for emergency cases in public A & E departments and for new cases referred to SOPDs.

## **Present Phenomenon (ii) and Consequences**

### *(ii) Imbalance between the public and private medical sectors*

5.28 There is a growing demand for hospital services due to population growth and ageing, as well as technological advancement that allows an increasing number of medical conditions to become treatable. Over 80% of patients requiring hospitalisation turn to public hospitals with the expectation that they will receive highly subsidised, low price and high quality service. The total number of public hospital admissions has thus increased by 73% from 0.64 million in 1990 to over 1.10 million in 2004 (Figure 13).

Figure 13: Public hospital admissions in 1990 and 2004



5.29 The current hospital utilisation pattern has resulted in a huge imbalance in market share between the public and private hospitals. The occupancy rate of public hospitals is approaching their limits, leaving little flexibility to respond to changing needs of patients or emergency events such as outbreaks of infectious diseases. Again, this is an unhealthy situation and is unlikely to be sustainable in the long run.

### **Recommendation**

5.30 We recommend the public hospital system to re-position itself and prioritise its services for the four target groups of public health care services set out in Chapter 3, viz. –

- acute and emergency care;
- for low-income and under-privileged groups;
- illnesses that entail high cost, advanced technology and multi-disciplinary professional team work; and
- training of healthcare professionals.

5.31 We also recommend private hospitals to take on a more active role in the provision of hospital services by specifically developing and providing services that do not fall within the priority areas of public hospital services.

## **Moving Towards the Future Model**

5.32 We recommend the Government to implement measures to re-focus the public hospital system to the four target groups. There should be a change to the current fees and charges policy, such that the subsidy levels for patients who do not belong to the low-income or under-privileged groups and who are not suffering from catastrophic illnesses could be reduced. However, the Government and the public medical sector should also consider other measures to redress the current imbalance between the public and private sectors. This may be achieved by co-ordinating with private hospitals the planning and further development of ambulatory services which are more affordable to patients.

5.33 We recommend that public hospitals may also consider operating more shared-care programmes, whereby the public and private sectors are each responsible for one part of the management for a specific patient<sup>1</sup>. The public sector may also help to reduce cost for the private sector (and hence the fees for their patients) by collaborating with and facilitating them in the procurement of drugs and equipment.

5.34 The private medical sector may consider developing or expanding services which are more affordable to patients, e.g. day surgery and other ambulatory services. We also recommend the private sector to work with

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<sup>1</sup> An example of these shared care programmes is in the provision of obstetric care for pregnant women in one of the clusters of HA. A pregnant woman can choose from a list of private obstetricians to receive personal antenatal care. The private doctor can refer the pregnant woman back to the public hospital in case of any medical problem. Delivery will be in the public hospital.

the insurance sector to bring about changes to insurance practices, thereby creating a larger market share for the private sector in respect of these services. In addition, private hospitals and doctors in private practice should take proactive steps to improve the transparency of their fees and charges, and to enhance their clinical governance.

### **Present Phenomenon (iii) and Consequences**

#### *(iii) Discharge problem*

5.35 Public hospitals are finding it difficult to discharge certain patients who are medically stable and no longer require hospital care. We recognise that some of these patients have problems of their own. Some require a high level of rehabilitation services or nursing care (but not medical attention) that cannot be provided at home. Others do not have the support required to sustain their long-term care needs in order to be managed in their own homes or in residential care homes. In short, such problems with discharge are in part due to insufficient post-discharge convalescent and rehabilitation support and facilities in the community.

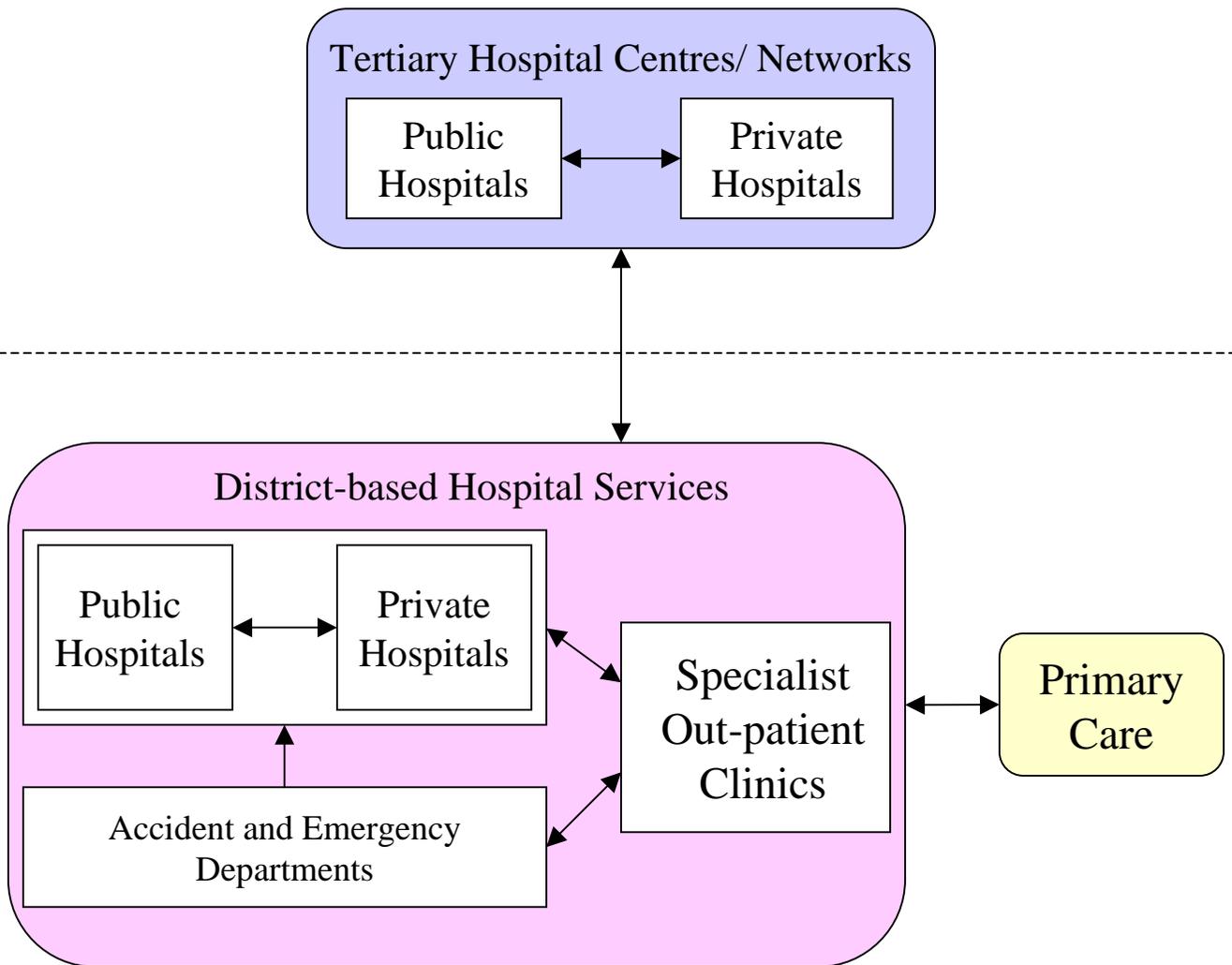
5.36 The consequences of this problem are poor quality of life for the patients concerned, shortage of hospitals beds for patients with genuine need and inefficient use of expensive hospital services. Should discharge problems continue to occur, there would be more adverse consequences including prolonged waiting time for patients with elective medical and surgical problems, aggravation of over-crowding in hospital wards during winter surge when there is a natural increase in the number of in-patients, and poor staff morale as the scarce resources are used on patients who

should be better managed in other levels of care facilities.

### **Recommendation**

5.37 We recommend the Government to proactively encourage the private and social service sectors to better develop post-discharge convalescent and rehabilitation services in the community to facilitate early discharge of medically stable patients. Detailed measures are set out in Chapter 7.

# Hospital Care Delivery Model



## ***Chapter 6 - Tertiary and Specialized Services***

### **Future Model**

6.1 The development of medical technology has enabled more complicated conditions to be treated. For the treatment of these conditions and further advancement of medical technology locally, we need –

*The establishment of specialised tertiary centres and hospitals to develop and concentrate expertise, technology, special facilities and research for the treatment of catastrophic illnesses.*

### *What are tertiary and specialised services?*

6.2 Tertiary and specialised services usually refer to services requiring highly complex and specialised care, usually through the application of advanced technology and specialised multi-disciplinary expertise. These services are usually required by patients with complicated but relatively less common diseases, or diseases that have developed uncommon complications, or what is described as catastrophic illnesses.

6.3 Although the number of patients requiring such treatment is small, the cost incurred by the provision of these services is inevitably high due to the requirement of major capital investment and multi-disciplinary expertise. Some examples of tertiary services are liver / heart / heart lung / pancreatic / bone marrow transplantation, complex surgery of infants and children to treat major solid tumours and radiosurgery of the brain

including the use of Gamma Knife. An example of specialised services is treatment of AIDS.

6.4 Some of the most complicated treatments available in public hospitals are classified by the HA as “quaternary services”. For convenience of discussion, they are also regarded as tertiary services in this discussion paper.

### **Present Phenomenon**

(i) *Public hospitals are the main providers of tertiary and specialised services*

6.5 At present, almost all tertiary and specialised services are provided at highly subsidised rates in public hospitals. Although some tertiary services are available in the private sector, their expensive costs limit the number of patients who can afford these services.

6.6 The current tertiary services provision in HA is concentrated in specific designated hospitals including the two Universities’ teaching hospitals and several major hospitals. The aim is to enable the professionals involved to accumulate as much experience as possible and for the services to be provided more cost-effectively.

(ii) *Tertiary and specialised services are highly subsidized*

6.7 The charging method in public hospitals for tertiary services is the same as for other services, i.e. a standard rate of \$100 per day plus \$50 admission charge. This charge is inclusive of all maintenance and

treatment charges. Furthermore, the charge for intensive care beds is also the same as that for general beds. Compared with the actual cost, the charge that the patient has to pay is minimal. For example, the cost of a liver transplant operation is \$540,000, excluding the post-operative follow-up and the immunosuppressant treatment. The average length of stay of a patient after liver transplantation is 10 days for which the patient needs to pay \$1,050.

*(iii) Increasing demand for tertiary and specialized services*

6.8 The ageing population, technology advancement and rising public expectation are contributing to an increasing demand for tertiary and specialized services. The cost of providing such services is expected to increase exponentially in the future.

### **Consequences**

6.9 It will be increasingly difficult for the public purse to meet the demand arising from both common and relatively easy-to-treat diseases that affect a large number of patients as well as catastrophic illnesses that affect a small number of patients.

### **Recommendation**

6.10 We recognize that it must remain the Government's commitment to provide services to the unfortunate minority suffering from catastrophic illnesses at a rate affordable to their families. On the other hand, we recommend that measures must be taken to ensure that tertiary and

specialized services are provided in a manner sustainable and affordable to the community, with a view also to preventing such illnesses from occurring as far as possible, to ensuring that these services are optimally configured to achieve cost-effectiveness and to encouraging the private medical sector to develop such services.

## **Moving Towards the Future Model**

### *The role of prevention*

6.11 As most patients will not be able to afford the cost of tertiary and specialised services, the Government must remain committed to providing these services to those who require them at a subsidised rate. However, it would even be better for the community if catastrophic illnesses can be prevented from occurring. Prevention is the best cost-containment measure. Many of the conditions and complications of diseases that eventually warrant tertiary and specialised care are preventable in their early stages. Life style modifications, effective vaccination programmes and effective management of chronic diseases can all contribute to reducing incidences of catastrophic illnesses or complications arising from chronic diseases. We recommend the Government to develop a more aggressive prevention strategy and instil in patients a sense of responsibility for their own health.

### *A larger patient co-payment element*

6.12 For patients who need tertiary and specialised services, we recommend that the Government should maintain the principle of providing the services at a relatively higher subsidy rate because of the high costs of

such services. However, we believe there is still room for the Government to consider a larger co-payment portion than the current level. The purpose of increasing the patient co-payment portion is not cost recovery, but the heightening of the community's and patients' awareness of the real costs of such services. Nonetheless, there should be a cap on the percentage of the patient's income and assets for the co-payment to limit the drain on the patient's resources by the treatment.

### *Other sources of funding for tertiary services*

6.13 Apart from the public purse, we recommend that the Government should also look to other sources to fund tertiary and specialised services and related research. The Government may, for instance, encourage the establishment of foundations for continued support of public or private centres providing these services or conducting research, and encourage continued donations to these foundations.

6.14 To maintain the momentum for continuous advancement and a high standard of medical practice, we recommend that the Government should encourage local research and collaboration among the public medical sector, universities and the private medical sector. To enable better planning for the development of tertiary and specialised services, the Government should also encourage the collation of relevant data to assess the needs of the local community.

### *Concentration of expertise*

6.15 It is recognized internationally that the quality and safety in tertiary care cannot be maintained without sufficient case volume in relevant specialised procedures. We note that HA is already on the right track in consolidating tertiary services in designated centres and recommend that this approach should continue. Nevertheless, we also recommend that planning guidelines based on caseloads and training demand should be worked out for tertiary services and be reviewed from time to time. We believe that where the caseload is relatively significant, it would be better to have two or more centres rather than one mega centre in order to achieve high quality service through healthy competition and collaboration.

### *Public-private collaboration*

6.16 Although most tertiary and specialised services are, and will continue to be, provided by the public sector, we believe the Government should encourage the private sector to develop tertiary services to help meet part of the demand, and to collaborate with the public medical sector to provide service to the community. While such collaboration already exists to a certain extent, there should be room for more of such efforts.<sup>1</sup>

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<sup>1</sup> Gamma knife surgery is an example of public-private collaboration. It is estimated that local demand would not justify more than one such equipment for the surgery. The service is at present available in a private hospital. There are special arrangements for patients of public hospitals who require the surgery to have the operation performed in the private hospital. If the patient does not have the means to pay for the cost of the surgery, the Samaritan Fund will provide financial assistance.

6.17 To make the best use of the small number of doctors trained in tertiary services, we recommend the public sector to consider engaging private sector doctors with experience in such services to practise on a part-time basis in public hospitals when the latter faces shortage of such skills. This arrangement will not only resolve the skill-shortage problem of public hospitals, but will also provide more opportunities for private sector doctors to accumulate experience and build up a reputation of excellence. Their reputation will attract foreign patients and develop a medical service industry for Hong Kong which will eventually benefit the entire economy.

## ***Chapter 7 - Elderly, Long-term and Rehabilitation Care Services***

### **Future Model**

7.1 A major focus of health care reforms in developed countries is directed towards minimising the use of hospitals in the management of chronic conditions. This entails the facilitation of early discharge of medically stable patients – even the very disabled – to the community to lead as normal a life as possible. In this respect, we envisage a future model of health care system comprising –

*Elderly, long-term and rehabilitation care services which encourage home care with community outreach and professional support, with infirmary and hospice care in all districts to enhance maintenance of family support.*

### **Present Phenomenon**

(i) *Insufficient professional support and facilities for patients' convalescence and rehabilitation outside hospitals*

7.2 At present, patients who can be discharged from hospitals but still require a high level of nursing and personal care often do not have appropriate institutions to turn to if the care they need cannot be provided at home. Some patients, particularly younger ones, may require only short-term rehabilitation and convalescent care, but the existing residential care homes offer only long-term care services and cater mainly to the elderly.

*(ii) On-site regular medical care for the elderly in residential care homes needs strengthening*

7.3 Regular medical care services for the elderly in most residential care homes for the elderly (RCHEs) can be improved. The existing licensing requirement for RCHEs in terms of medical care only stipulates that they should ensure their residents receive medical check-up at least once a year. The public hospitals have set up Community Geriatric Assessment Teams (CGATs)<sup>1</sup> with the intention to provide timely assessment for elderly people on the waiting list for public infirmary care as well as outreach specialist medical and rehabilitative support to RCHEs. In addition to CGAT visits, RCHEs rely heavily on the A & E departments of public hospitals to treat acute illnesses of their residents, and public SOPDs to manage their chronic illnesses. However, not all RCHEs provide on-site regular medical care for their residents, especially those receiving elders at care-and-attention level.

*(iii) Insufficient manpower for geriatric nursing and for providing nursing care in the community setting*

7.4 Much of the work involved in rehabilitative care, care for the elderly and people with disabilities (particularly in the management of stable chronic illnesses) can, in fact, be done effectively by qualified nurses. However, at present the establishment of community nurses in the public sector is still small. Existing Community Nursing Service (CNS) of the HA usually only covers basic medical care for mostly elderly patients discharged from public hospitals.

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<sup>1</sup> CGAT comprises geriatricians, nurses, physiotherapists, occupational therapists with support by dietitians and speech therapists.

7.5 Furthermore, community nurses and other health care professionals are seldom engaged by primary care doctors in the private sector to help deliver service to patients with chronic illnesses, and few nurses outside the CNS are available for such employment either.

7.6 In recent years, it has also been difficult for RCHEs to recruit qualified nurses. Young graduates of nursing prefer the greater variety of challenges and opportunities as well as better promotion prospects offered by public hospitals. This problem is also shared by many countries overseas. It is noted that some overseas countries have begun training a type of health care workers (with nursing capabilities to the level of a registered nurse) specifically for RCHEs and for the elderly. The training aims at providing these health care workers with multiple skills and enabling them to take care of elderly independently.

### **Consequences**

7.7 As a consequence, medically stable patients who do not need hospital care any more but require some rehabilitation and nursing care tend to stay for a prolonged period in public hospitals because of insufficient post-discharge convalescent and rehabilitation support and facilities outside the hospital setting. Similarly, some individuals with long term care needs who could be managed in their own homes with some support or in residential care homes, are staying in public hospitals on a long-term basis. There are also frequent admissions and readmissions of

RCHE residents to public hospitals, especially during non-office hours, for illnesses the implications of which are uncertain to the homes' workers or for qualified nursing care, in particular from RCHEs not staffed with nurses. All these contribute to a shortage of hospital beds for patients with genuine medical need and thus inefficient use of public hospital resources.

## **Recommendation**

7.8 We recommend that -

- residents of RCHEs and residential care homes for the disabled (RCHDs) should have regular primary medical care provided in their living environment.
- medically stable patients should be discharged from hospitals to the community to lead as normal a life as is possible. This should be facilitated and supported by smooth interfacing between hospital, rehabilitative care and primary medical care services.

## **Moving Towards the Future Model**

### *For elderly care services*

7.9 We recommend the Government to consider changing the licensing condition of RCHEs to require them to engage doctors to take care of their residents' medical needs on a regular basis. The objective is to improve the overall medical care for the elderly in residential care homes and to have in place a gate-keeper to prevent unnecessary frequent hospital admissions as well as to prevent delayed treatment of emergency cases in

need of hospitalisation. We note that the Social Welfare Department is in the process of revising the Code of Practice for RCHEs to encourage more frequent visit by doctors engaged by RCHEs. This is a positive move that should be supported by all stakeholders.

7.10 With RCHEs taking on greater responsibility for medical care of their elderly clients, the public sector should re-position itself in this respect. We recommend CGATs to concentrate on discharge planning and providing support to doctors engaged by RCHEs through consultations and joint conferences for elderly residents who have multiple, complicated medical problems, while doctors engaged by RCHEs should attend to the basic medical needs of the residents. To develop good co-operation and interface between CGATs and doctors engaged by RCHEs, we recommend the public medical sector to initiate discussions with doctors engaged by RCHEs with a view to developing and adopting shared care programmes and referral protocols.

7.11 Under this proposed model, the private sector will have a greater role in the primary medical care of the elderly. We recommend doctors in private practice, especially primary care doctors, to be prepared to depart from the traditional mode of providing services in the clinics and to offer out-reaching services to RCHEs. We also recommend the same model to be adopted by RCHDs.

### *For long term and rehabilitation care services*

7.12 For medically stable patients who can be discharged from hospitals but require temporary rehabilitative care that cannot be provided at home, we believe that the development of a new type of short-stay institutions providing temporary convalescent and rehabilitation services is the answer. We recommend the Government to encourage the private and the social welfare sectors to develop such institutions.

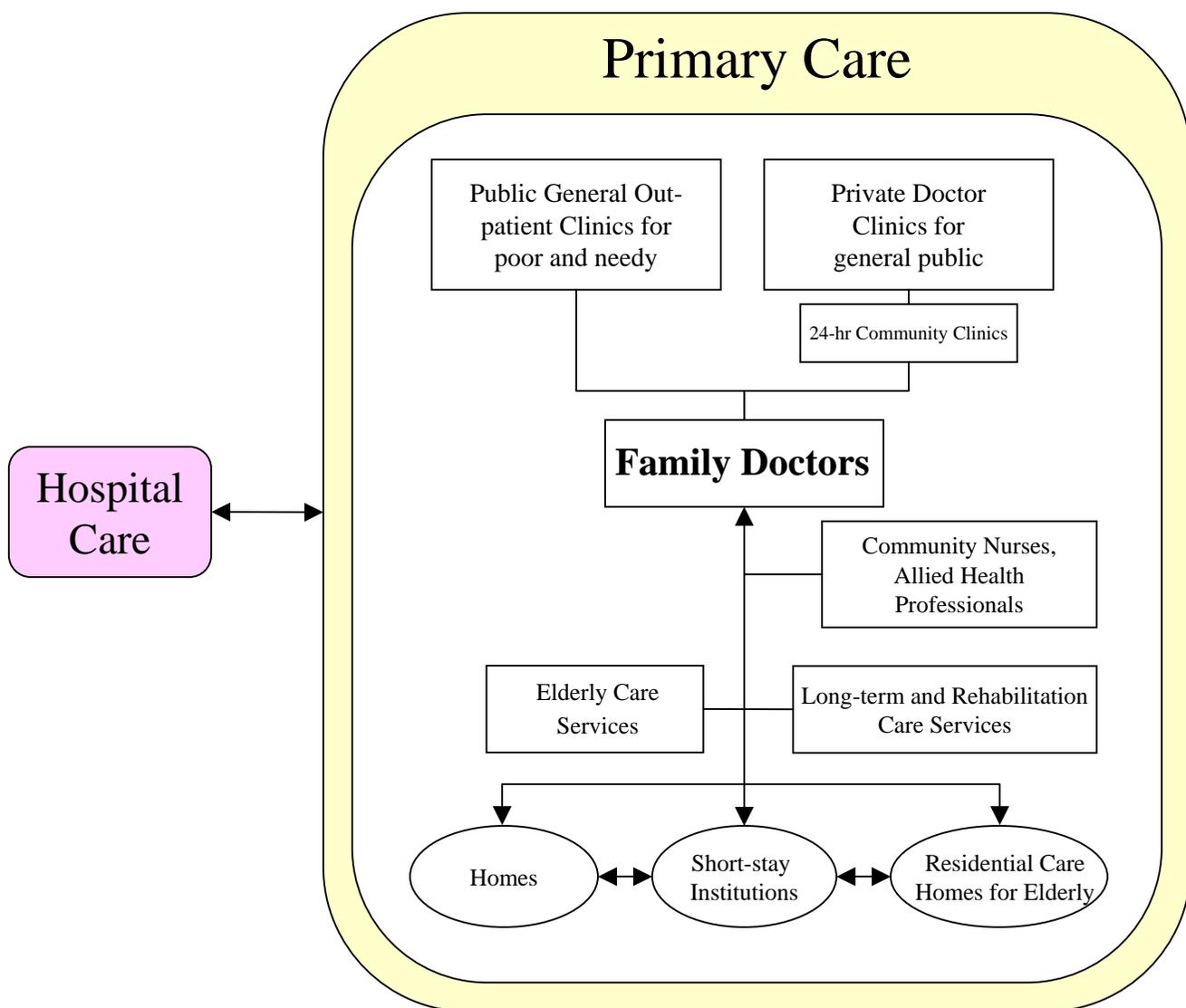
7.13 We also recommend the public sector to expand its CNS to enable it to take up comprehensive primary care roles in addition to the current home care services, particularly in the management of chronic illnesses. This would not only improve the convalescence and rehabilitation process of patients, but also help those with chronic illnesses to adopt a healthier lifestyle towards the prevention of complications requiring specialist consultations or hospitalisation. We note that there is still a shortage of nursing manpower at present. However, with the increase in the number of nursing graduates in the coming years, the situation would improve and there should be room for the CNS to expand. The public sector may also make greater use of allied health professionals to design and implement home rehabilitation programmes in conjunction with CNS to integrate physical rehabilitation into the daily care of patients in the community.

7.14 We recommend that the private sector consider the business case of developing short-stay institutions that could provide temporary convalescence and rehabilitation services for patients with such needs.

We also recommend doctors in private practice to refer deserving cases to CNS so that patients from both private and public hospitals have equal access to the service. With better community convalescent and rehabilitation support, more patients may choose to receive treatment of their acute conditions in private hospitals. The private sector may also consider setting up their CNS to serve patients who have the financial means to afford the service.

7.15 Other sectors in the community also have a part to play to realise the potential improvements that may be brought about by this model. We recommend RCHEs and RCHDs to take on the responsibility of providing regular medical care to their residents. To meet the demand for nursing care arising from an ageing population, we also recommend universities and training institutions to consider additional training and qualifications for those who would like to pursue a career of community nurse. Making reference to overseas experience of employing specially trained health care workers with capability to take care of elderly independently on a par with nurses, we recommend tertiary education institutions and training institutions to consider offering similar training programmes.

# District-based Primary Care Delivery Model



## ***Chapter 8 - Integration between the Private and Public Sectors***

### **Future Model**

*Well-integrated public and private sectors which promote healthy competition in terms of service quality and professional standards, and provide a choice for the public.*

8.1 In the previous chapters, we have recommended the private medical sector to take on a larger share of the services to be provided. The aim is not merely to redress the imbalance between the public and private sectors but also to achieve an overall improvement in the quality of care for patients and thus sustainability of the healthcare system.

8.2 Hitherto the public and private sectors are often seen to be having distinctly different service targets. For the future, we believe that the same patient can be taken care of by public and private health care institutions at different stages, depending on his / her conditions. We also envisage skill transfer and cross-sector training to take place, so that the community can make the most of the expertise and special knowledge available. Where there is room for co-ordinated planning to avoid over-provision of resources, especially expensive equipment and facilities, or to reap the greatest benefit for our patients, such as co-ordinated drug or vaccine procurement, we also believe the public and private sectors should work together.

8.3 The two sectors should not only aim at more collaboration and co-operation but also integration to provide quality service to the public. For services which are provided by both sectors, given the positioning of the two sectors in Chapter 3, there should be healthy competition instead of pre-dominance by any one sector.

8.4 A summary of the way we see how the public and private sectors should integrate is as follows –

### **Patient Care**

#### *Primary medical care*

- Government to enhance the identification and assessment of the impact of social and environmental variables on health and to improve communication of this information to family doctors to enable the latter to provide effective preventive care to patients.
- Family doctors to communicate more frequently with other professionals, including professionals in Government departments, to resolve patients' problems beyond the patients' physical condition which nevertheless affect the latter's health.
- The public sector to provide part of its primary medical care service through purchasing such service from the private sector with the objective of improving the quality of primary medical care.
- Government to develop standards of care, including preventive care, for different age groups and different patient groups for reference by family doctors.

### *Hospital services*

- A&E departments of public hospitals to –
  - share with family doctors and 24-hour clinics in their districts their triage criteria and waiting time for different triage categories; and
  - establish links and protocols with family doctors and 24-hour clinics in their districts, such that consultation and transfer of patients with real emergency conditions identified in 24-hour clinics or by family doctors are expedited, with minimal waiting time before attended to by A&E specialists on arrival at a public hospital's A&E department.
- Public hospitals to establish referral protocols and shared-care programmes with family doctors for the care of chronic patients who are medically stable.
- Public hospitals to operate more shared-care programmes whereby the public and private sectors are each responsible for one part of the management for a specific patient.

### *Tertiary and specialised services*

- Public and private sectors to collaborate more to provide tertiary and specialised services to the community.

### *Eldery, long-term and rehabilitation care services*

- CGATs of public hospitals to concentrate on discharge planning and providing support to doctors engaged by RCHEs through consultations and joint conferences for elderly residents who have multiple,

complicated medical problems, and doctors engaged by RCHEs to attend to the basic medical needs of the residents.

- Doctors in private practice to refer deserving cases to CNS.

#### *Training of professionals and skill transfer*

- The public sector to engage private sector doctors with experience in tertiary and specialised services to practise on a part-time basis in public hospitals when the latter faces a shortage of such skills.
- CGAT of public hospitals to transfer skills in managing medical problems of residents of RCHEs to doctors engaged by RCHEs.

#### *Others*

- The public sector and private hospitals to co-ordinate the planning and development of ambulatory services so that resources in the two sectors can be maximized.
- The public sector to collaborate with the private sector in the procurement of drugs, vaccines and equipments.

## ***Chapter 9 - Infrastructural Support***

9.1 Apart from re-positioning of the public and private sectors in terms of the provision of health care services and closer co-operation between our service providers, our future service delivery model has to have the following infrastructural support -

### *A more aggressive prevention strategy*

9.2 This is the best means to improve the health of our population and to contain cost. Effective preventive care reduces the incidence of both communicable and non-communicable diseases. Whilst a lot has been done in the past regarding the prevention of communicable diseases, non-communicable diseases (NCDs) have become the leading cause for morbidity, disability and mortality all over the world. Many of these NCDs are preventable. In general, prevention can be classified into three levels: primary (prevent onset of disease), secondary (early detection) and tertiary (rehabilitation). Please see Annex C for details.

9.3 We recommend the public sector to review its strategies in delivering preventive care at all levels and explore whether there is room for more collaboration with the private sector in this respect. For the private sector, we believe that their services should be re-oriented from curative care to paying greater attention to primary and secondary level preventive activities and health maintenance. This is especially relevant in elderly care. The primary care doctor is in a unique position to provide

comprehensive care to the elders in the community to help minimize disease and disability due to complications while optimizing functional status to preserve their independence and prevent or delay institutionalization. We note that there is a general tendency, particularly for the elderly, of not reporting health problems such as visual impairment, incontinence, history of fall or depressive moods unless and until they fall sick. Hence it is important for their doctors to actively look out for these problems, and to incorporate opportunistic screening into everyday curative care encounters.

#### *Promotion of free flow of patient records*

9.4 In order that our future service delivery model can facilitate the best use of resources and provide the flexibility and dynamism necessary for the transition of patients between different levels of care and between the public and private sectors, it is essential to develop a system which enables free flow of patients' records with the patient's consent. This is also fundamental to the successful development and implementation of referral protocols and shared care programmes.

9.5 We believe that the public sector should take the lead to create an environment that encourages and a system that facilitates the free flow of patients' medical record. This may be implemented in phases. The short-term aim should be to provide patients of all General Out-patient Clinics and SOPDs with hand-held record and to encourage private doctors to do the same. In the long term, we believe that there should be

the development of a territory-wide information system for carers in both public and private sectors to enter, store and retrieve patients' medical record. Access to individual patient's record needs to be properly authorized by the patient himself or herself.

### *Training for professionals in different roles*

9.6 The future service delivery models will only be successfully implemented if the professionals concerned are equipped with the requisite knowledge and skills. We have highlighted in previous chapters certain gaps in the training of health care professionals, e.g. training health care workers specifically for geriatric caring, training for primary care doctors to take care of residential-home-bound elders. The required change in emphasis from curative care to both preventive and curative care, and from specialist care in managing chronic illness to relying more on primary care doctors for management of stable chronic conditions will require the medical profession, especially primary care doctors, to adopt new mindset and acquire new knowledge and skills.

9.7 We suggest training institutions as well as the professions themselves to review the content of the training currently offered to undergraduates and in-service professionals to prepare them for the challenges ahead. The professions should also positively consider how best to ensure continuous education of their members.

### *Fees and charges policy*

9.8 We believe that the Government should put in place a fees and charges policy that is conducive to achieving the re-positioning of public health care services as set out in Chapter 3; minimizing the inappropriate use, misuse or abuse of public health care services; discouraging patients to adhere unnecessarily to most expensive services; and more importantly, fostering in patients a sense of responsibility for one's health.

### *Improvement in means testing of patients*

9.9 If our public sector medical services are to be re-positioned to target at the low-income group and the underprivileged as set out in Chapter 3 and the public purse be used in the most appropriate place and at the most appropriate level, we believe that a more refined assessment will be needed to determine the financial needs of a patient and to enable different subsidy level to be provided for patients with needs of differing degrees.

### *Public education*

9.10 Last but not least, we believe that there should be a rigorous public education programme which seeks to correct certain misconceptions commonly found, e.g. that specialist care is superior to primary care, that primary care doctors are meant for curing episodic illnesses only, that A&E departments in public hospitals is the only resort after normal consultation hours. We should inculcate in patients a sense of responsibility for one's health and the awareness that one must seek the right level of medical help

and the right person to help; and bring home to patients the importance of prevention and adoption of a healthy lifestyle.

## ***Chapter 10 - Conclusion***

### *Hong Kong's future health care scene*

#### **10.1 “What will Hong Kong’s health care scene be like in 10 – 15 years’ time if the recommendations in this discussion paper are successfully implemented?”**

- “Every family or citizen of Hong Kong is under the continuous care of a named doctor of his / her choice, who is located mostly close to his / her home.
- More preventive care is provided to patients. There are regular health checks, depending on age, past health history, and family history for every person, available at a moderate price.
- A territory-wide medical record system is in place. With patients’ consent, doctors in the public and private sectors can all access their patients’ records and make better informed treatment decisions.
- Patients can have access to hospitals of their choice when in need, and enjoy close links with their respective carers.
- 24-hour community clinics offer useful service to patients with acute conditions. Many family doctors are also willing to offer assistance to patients with acute conditions after their clinics’ opening hours.
- Emergency cases are treated by A & E departments in a most timely manner. The effective use of observation wards has significantly reduced the need for admission through A & E departments.

- Services for the elderly, chronically ill and rehabilitating patients reach out to the community. Visiting medical, nursing and allied health teams reach out to residential care homes or families.
- Elderly individuals rarely need to be admitted through A & E departments just for diagnostic exclusion. All RCHEs and RCHDs have their own primary care doctor looking regularly after the medical needs of their elders.
- With an appropriate fee differential system, there is better private-public market distribution, and room for development of tertiary services and centres of excellence, in both public and private institutions and facilities.
- Patients with chronic illnesses are being cared for by joint efforts of specialists and their family doctors. Useful advice from family doctors confines the need for patients to devote time and resources to specialist care to that which is necessary and essential.
- Patients who cannot afford the fees of public services are subsidized to varying degrees, according to their financial situation.
- Workload in public hospitals and clinics is less heavy for our young health care professionals whilst providing them with sufficient opportunities for training. There is a healthy turnover of staff in both the public and private sectors.”

### *Past reviews*

10.2 Public debate on Hong Kong’s health care financing policy could be dated back to 1993 when the document “Towards Better Health”,

commonly known as the “Rainbow Report”, was published by the Government. In 1997, the Government commissioned the School of Public Health of the Harvard University to conduct a study on the existing health care system and to recommend changes. The study was completed in 1999 with the release of a report entitled “Improving Hong Kong’s Health Care System – Why and for Whom?” Based on the comments received, the Government issued a further consultation document on health care reform in late 2000, entitled “Lifelong Investment in Health”. In 2004, a paper on “Studies on Health Care Financing and Feasibility of a Medical Savings Scheme in Hong Kong” was presented to the Legislative Council Panel on Health Services.

10.3 In the reviews that have taken place in the past, it was generally recognized that the sustainability of Hong Kong’s long term health care is an issue that needs to be addressed. However, consensus has yet to be reached as to how this issue and the related issue of health care financing should be addressed.

#### *Next steps*

10.4 This discussion paper is a continuation of past reviews. We hope to be able to build consensus in the community through a step-by-step approach. This discussion paper contains our recommendations on the future service delivery model. As a next step, we will proceed with discussions on the possible financing options and we will put forth recommendations in this regard by end of 2005 / early 2006.

10.5 The objectives of defining our future service delivery model are to rationalize and maximize the use of resources in both the private and public health sectors so that we can have a sustainable health care system. Should resources be identified in some service areas in the process, they will be ploughed back into the system for the purpose of enhancing services in other areas.

*Looking forward to your support*

10.6 We have set out the direction for moving towards the future service delivery model in this discussion paper. Your support is paramount. We look forward to receiving your views. Please write to us before 31 October 2005 to -

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July 2005*

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The Three Levels of Prevention

(Adapted from “Essential public health. L.J.Donaldson. Second Edition)

- Primary prevention: this refers to measures that prevent the onset of disease. The important strategies include health education, immunization, environmental measures and social policy. The ultimate goal is to alter some factor in the environment, to bring about a change in the status of the host, or to change behavior so that disease is prevented from developing. It had brought about many of the triumphs of public health in the past especially those related to infectious diseases.
- Secondary prevention: this aims to stop the progression of a disease once it is established, by early detection, early diagnosis followed by prompt, effective treatment. It is often also taken to mean the prevention of relapse or recurrence of disease conditions through intervention or attention to lifestyle improvement measures e.g. smokers to quit smoking after a heart attack. Screening for early detection of disease has become popular among the public as a means to “prevent” diseases. However, special consideration and careful evaluation is necessary before such screenings of asymptomatic individuals is carried out on a population scale. The factors to consider include : prevalence of the condition (cost-effectiveness of the screening), sensitivity and specificity of the screening tests (implications on false positives and false negatives), any effective treatment available for early stages of the disease, any hazard of the screening, etc.
- Tertiary prevention: it refers to the proper rehabilitation of patients with an established disease to minimize residual disabilities and complications. Action taken at this stage aims at improving the quality of life, even if the disease itself cannot be cured.