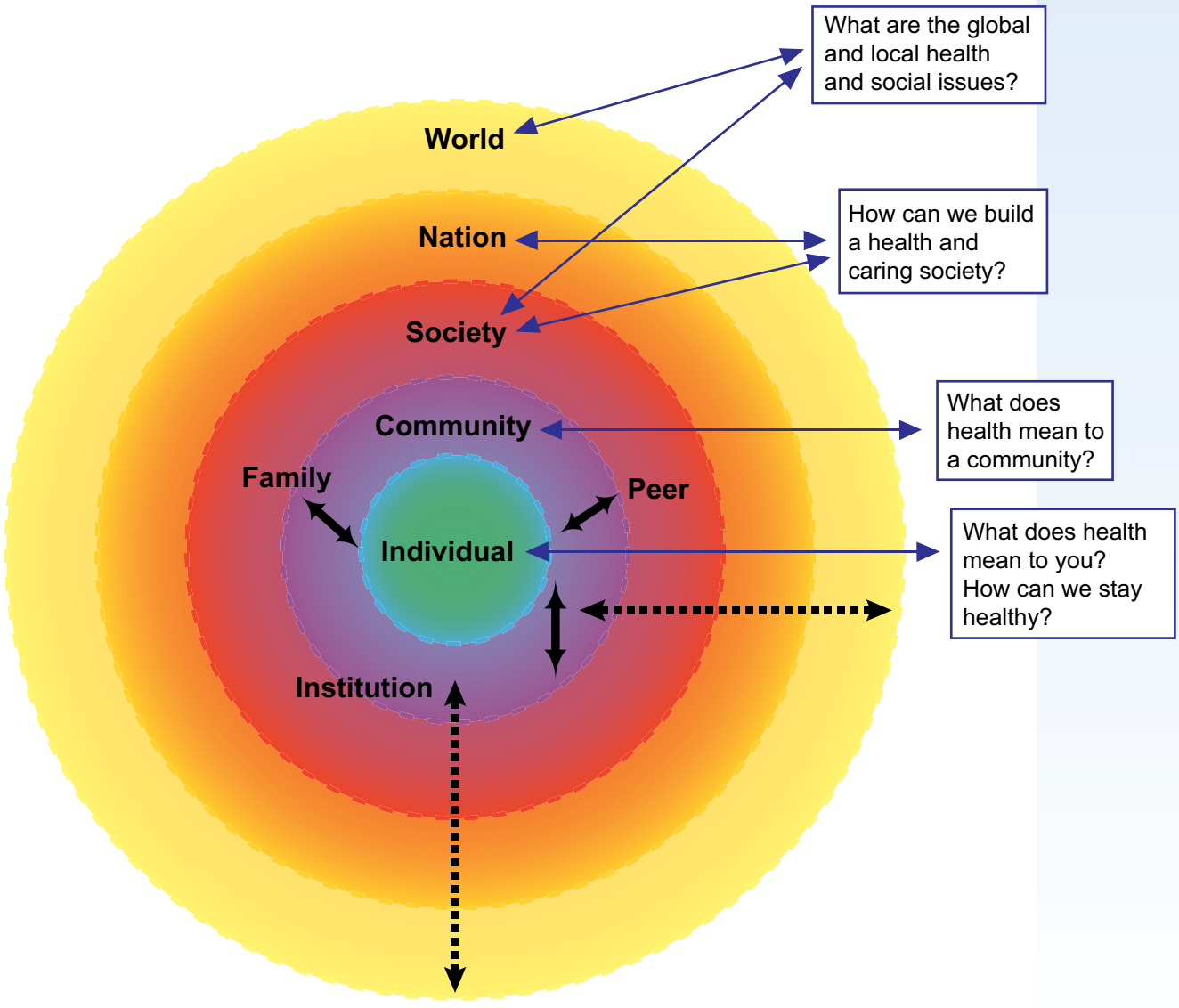
10
Healthcare System

Health Management and Social Care (Secondary 4-6)

Health Management and Social Care Booklets

The design of the HMSC curriculum rests on the notion of the interconnectedness of the various levels at which phenomena related to health and sickness, well-being and ill-being, and personal and community care are to be understood. The curriculum aims to enable students to explore all of these levels as well as the relationships between them. The different levels can be interpreted as the individual, the family, the peer group, the community, the institutional setting, society, the nation and the world (Figure 1).

Figure 1 The Various Levels and Essential Questions of HMSC



This part includes 19 booklets of learning and teaching reference materials for teachers. The topics and information in these booklets are selected and organized based on the five essential questions from various levels mentioned in the curriculum design in Chapter 2 of the Health Management and Social Care Curriculum and Assessment Guide (Secondary 4-6)(2007). The booklets facilitate teachers to develop an overall framework of HMSC and identify the key concepts of the curriculum so that their students will be more able to critically assess the relevant issues. Details of these booklets are as follows:

Levels	Essential Questions	Booklets	
Individual, Family and Peer	What does health mean to you?	1	Personal Needs and Development across Lifespan
		2	Health and Well-being
	How can we stay healthy?	3	Physical Well-being - Healthy Body
		4	Mental Well-being - Healthy Mind
		5	Social Well-being - Inter-personal Relationship
Community	What does health mean to a community?	6	Healthy Community
		7	Caring Community
		8	Ecology and Health
		9	Building a Healthy City
Society	How can we build a healthy and caring society?	10	Health Care System
		11	Social Welfare System
		12	Medical and Social Care Professions
		13	Health and Social Care policies
		14	Social Care in Action
Local and Global Societies	What are the local and global health and social issues?	15A	Health and Social Care Issue - Ageing Population
		15B	Health and Social Care Issue - Discrimination
		15C	Health and Social Care Issue - Domestic Violence
		15D	Health and Social Care Issue - Addiction
		15E	Health and Social Care Issue - Poverty

Each booklet will start with the essential questions. The expected learning outcomes in terms of knowledge, skills, value and attitude as well as the content outline will be listed as an overview. Teachers are advised to adapt and flexibly use the materials based on school or community situation, background of students, interest, learning skills and the prior knowledge of students. Social issues as well as the graphic organizers that illustrated in Booklet 3.1.5 can be used to help student organize and analyze complex and abstract concepts, construct their knowledge effectively and achieve deep understanding.

How can we build a healthy and caring society?

The holistic concept of health has been elaborated from different perspectives and dimensions in Booklet 1 -9. In Ottawa Charter, definition of health is further elaborated as ‘a resource for everyday life, not the objective of living. It is a positive concept, emphasising social and personal resources as well as physical capabilities.’ If health is the social and personal resources, it needs to be properly managed.

Simply speaking, management is to guarantee the use of resources in the most appropriate way in the most appropriate time and place through planning, organising, directing, coordinating and controlling the use. Management is not just the concern of government and commercial organisations. Non-governmental organisations and other social care organisations also need to be properly managed. Therefore, health management is planning, organising, directing, coordinating and controlling the resources to meet the health needs. In Booklet (10) to (14), it is explored how to achieve holistic health through organising, allocating and utilizing resources from the levels of the system, policy, professionals and professional services.

The topics of Health Management and Social Care Curriculum and Assessment Guide included in the Booklet 10-14 are listed in the following table:

Booklets		Topics in HMSC Curriculum and Assessment Guide
10	Health Care System	Compulsory part 2D Developments in the health and care industries
11	Social Welfare System	3B Developing health and social care / welfare policies 3C Implementing health and social care policies 3D Cultural and political disagreements and tensions 4A Disease prevention (primary, secondary and tertiary) and using precautions in our daily living patterns and lifestyles
12	Medical and Social Care Professions	Compulsory part 5A Professions in health and social services 5B Health and social care services and agencies
13	Health and Social Care Policies	Compulsory part 3B Developing health and social care / welfare policies 3C Implementing health and social care policies 3D Cultural and political disagreements and tensions
14	Social Care in Action	Compulsory part 4D Social care, healthy relationships, social responsibility and commitment in the family, community and groups 5A Professions in health and social services 5D Leadership in health and social care

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Learning Targets

Through the study of the topic on healthcare system, students are expected to:

Values and attitudes

- Understand that value judgments may vary among different individuals or parties
- Analyse and appreciate viewpoints or issues from different perspectives
- Respect cultural and ideological differences
- Appreciate alternative healthcare practices

Knowledge

- Understand the concepts of health care
- Understand how the development of healthcare system is affected by social factors
- Identify the issues and concerns related to the healthcare system
- Identify instruments of policies
- Compare healthcare policies in Hong Kong with other regions / countries
- Understand the conflicts and tensions in the healthcare context
- Develop personal opinions on healthcare policies

Key Questions

To achieve the above learning targets, teachers may use the following questions to enhance understanding:

- What is health care?
- Why does the existing healthcare system need to be reformed?
- In what ways can a healthcare system build a healthy community for all?

10.1 Development of Healthcare System in Hong Kong

Primary Health Care (PHC), in World Health Organization's definition, is the essential healthcare made accessible to people at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable. It is based on the belief of 'health for all' which was proposed and was formally put forth in the 1978 Alma-Ata Declaration. The Declaration of Alma-Ata was clear about the values pursued: social justice and the right to better health for all, regarding participation and solidarity.

To what extent can the healthcare system in Hong Kong build on these values and achieve the goals of the PHC proposed by World Health Organization? This booklet aims to outline the framework, development and concerns about the healthcare system in Hong Kong. As the ageing population is a global and local trend which has an impact on the healthcare system, especially the healthcare financing, the series of healthcare reforms aiming at solving this problem will be introduced. Students are expected to be able to evaluate and develop their view points on the healthcare system and healthcare reform.

The healthcare system in Hong Kong has undergone many changes to meet the challenges of the healthcare needs. The major milestones of the development of the healthcare system are outlined in the table on the next pages:

Period	Critical Events
1840s	In 1841, the government of the Qing Dynasty was defeated by the British government in the Opium War. Due to the cession of Hong Kong Island, Hong Kong became the British colony for over a hundred years.
	There was no healthcare system or health policy in the initial stage in the colonial period.
	At that time, most of the hospitals and medical equipment were procured for the British officials in Hong Kong. It had been changed gradually.
	During this period, the government focused only on sanitation and disease control by a **Committee of Public Health**.
	The colony adopted a **"laissez-faire"** administrative approach in medical services.
	Government medical services were first introduced in Hong Kong in 1843 with **the appointment of a "colonial surgeon"** whose patients were mainly garrison and European residents in Hong Kong.
1850s - 1960s	In 1854, 70 soldiers died of dysentery when they got ashore.
	An epidemic killed more than 800 people during February to April in 1855.
	A number of **government hospitals** were set up with services mostly to cope with **mental disorders, contagious diseases;** and largely for **government employees**.
	Most local residents went to **private traditional Chinese medicine practitioners**.
	The Chinese lived at Tai Ping Shan Street at that time. Most of them were living alone. They had no relatives when they died. Kwong Fuk Tsz (also named as People Temple) was used to enshrine and worship the ancestors of these homeless people. After the plague, the Chinese leaders strove to build hospitals for the Chinese. The first private charity hospitals – the Tung Wah Hospitals was then set up.
	On 26 March 1870, the first hospitals for the Chinese - the Tung Wah Hospitals were established. 'Tung Wah' means the Chinese in Guangdong. It was staffed by both traditional and western medical practitioners at that time.

Period	Critical Events
1850s - 1960s	Sai Ying Pun Hospital (also known as Government Civic Hospital) was founded in 1874 at Queen's Road West. It was the first public non-military hospital in Hong Kong.
	The establishment of Nethersole clinic in the Victoria Peak was another important development in medical services for the local residents. Nethersole was named after the mother of Davis, a member of the former London Missionery Society (now it is called the Council for World Mission).
	In 1887, Sir Kai Ho built Alice Memorial Hospital in memory of her beloved wife who died in 1884. It was the first hospital in Hong Kong that served the local poor Chinese with western medicine.
	In the same year (1887), the Hong Kong Chinese College of Medicine was established, pioneering the local medical training through setting up the teaching hospital in Alice Memorial Hospital.
	In 1904, the Alice Memorial Hospital, the first maternity hospital in Hong Kong and China, was set up.
	In 1906, due to the shortage of hospital beds, the sister of Sir Kai Ho, Ho Miu Ling, donated money to build the Ho Miu Ling Hospital.
	Due to the overcrowding problem, the Alice Memorial Hospital merged with the Nethersole Hospital and Ho Miu Ling Hospital to become Alice Ho Miu Ling Nethersole Hospital in 1954.
	Although Hong Kong's medical facilities were improving, in the spring of 1894, an epidemic broke out in Guangzhou, leading to the death of more than 100,000 people. In the same year in May, in the vicinity of Tai Ping Shan Street, Sheung Wan, where the Chinese people concentrated and inhabited, the plague broke out. Over a hundred people died everyday. Consequently, over 2,552 people died of plague. About 100,000 Chinese left Hong Kong and trade declined.
	After that, the plague occurred occasionally during the thirty years. 1,290 people died of plague from 1898 to 1900.

Period	Critical Events
1850s - 1960s	At that time, the government adopted an extreme policy to demolish a number of Chinese accommodations to force the people to move out. Simultaneously, the Tung Wah Hospital Board tried to control the plague by asking the immigrants, mostly the coolies, to register their addresses in order to manage the public health condition. However, it was strongly opposed and led to a strike in the port. During this period, the control of plague did not rely on effective medicine, but on working hard to achieve public health. 'Washing Tai Ping Tei' was one of the important measures at that time.
1964	A **White Paper on the Development of Medical Services in Hong Kong** was issued by the government. It was followed by the expansion of government clinics and hospitals, in accordance with the government policy to provide subsidized or free medical and personal health services for all those unable to purchase or obtain care from other sources.
	After that, there was no major development in the healthcare system in Hong Kong until the governor Sir MacLehose who led Hong Kong into a golden age of reform.
1970s - 1980s	**Medical Development Advisory Committee (MDAC)** was appointed by the government in 1973, re-constituted in 1992 as the Health and **Medical Development Advisory Development Committee (HMDAC)** to provide a continuous review and advisory service for the development and implementation of medical and health services.
	In 1974, a re-statement of government health policy in the **White Paper "The Further Development of Medical and Health Services in Hong Kong"** tabled in incremental development rather than radical changes of direction. It proposed medical and health services to be organised on a regional basis.
	During this period, there was rapid expansion of hospital facilities, but slower increase in general outpatient services and clinics in providing primary medical care. More than 70% primary medical consultations took place in the private sector. Further outpatient services were provided under an arrangement between the **Housing Authority and the Voluntary Estate Doctors Association** through which about **300 public housing estates set up low-cost clinics for residents.**

Period	Critical Events
1970s - 1980s	Development of primary health care was limited to the **community-based maternal and child health services.**
1980s - 1990s	Responding to the calls for a review of hospital medical services and their administration, the Executive Council approved a review in 1984. The consultant report - the **"Scott Report"** was issued in December 1985 with recommendations to establish a statutory authority to provide hospital medical services and their administration.
	In 1987, the government decided to establish the Hospital Authority as a statutory authority to oversee and manage the provision and delivery of services in an integrated hospital service which would encompass all government and subvented hospitals.
	On 1 October 1988, the **Provisional Hospital Authority** was established.
	On 1 April 1989 the **Medical and Health Department** was split into the **Department of Health** and the **Hospital Services Department.**
	On 1 December 1991, the **Hospital Authority** formally took over the management of the 15 government and 23 subvented hospitals and institutions in order to provide an integrated public hospital services.
	The provision of public health and preventive programmes became the responsibility of a government department - the **Department of Health.**
1990s - 2000s	In 1993, the consultation document "Towards Better Health" was published which advocated subsidising medical services according to the affordability of clients.
	With the return of sovereignty in 1997, the first policy address of the Chief Executive promised to conduct a comprehensive health reform.
	The Harvard's Report was published in 1999, proposing health financing models.

Period	Critical Events
2000s onwards	The health financing models encountered resistance in 2001. It was known as offering a long term scheme which included health management and contributory saving. In the mean time, the structure of medical costs and charges of public health services were under review.
	In 2002, the new charge, $100, was adopted for the A&E service in hospitals. The new charges were also effective in other health care services in public hospitals since 2003.
	The **consultations on the reform of health care financing** started but no substantive action was taken due to the resistance created by socio-economic and political factors.
	The management of 59 General Outpatient clinics transferred out from Department of Health in 2003.
	The Hospital Authority became responsible for delivering a comprehensive range of secondary and tertiary specialist care and medical rehabilitation through its network of healthcare facilities.
	The Hospital Authority also provided some primary medical services in 74 primary care clinics.
	Responding to the SARS Expert Committee Report, the **Centre of Health Protection (CHP)**, was set up in 2004. It aims to provide systems on disease control to tackle health threats and to respond to outbreaks of infectious diseases in collaboration with local and international health organisations.
	Public private interface (PPI) in health service delivery is being developed to provide more choices for patients as well as maximize the use of combined resources between the public and private health sectors.
	A healthcare reform consultation **'Your Health Your life'** was launched in 2008 to seek public views on the future development of the Hong Kong healthcare system and financing arrangement. In the consultation paper, the reform is proposed to be undertaken in five areas including: enhancing primary care to put greater emphasis on preventive care, promoting public-private partnership in health care, developing electronic health-record sharing, strengthening the public healthcare safety net, and reforming healthcare financing arrangements.

10.2 Healthcare System in Hong Kong

Healthcare services in Hong Kong are customarily categorized into three levels, namely, primary, secondary and tertiary medical care, depending on the nature of services required.

(A) Three Levels of Medical Care

1. Primary medical care

In the following part, primary medical care mainly refers to the medical part of primary healthcare. It is the first point of contact that patients make with their doctors, such as general practitioners. It covers curative and preventive care, continuing care, health promotion and education, as well as referral to specialists.

2. Secondary medical care

Secondary medical care refers to specialist medical care and hospital care. Secondary medical care services include acute and convalescent in-patient care, day surgery, specialist out-patient, and Accident and Emergency services.

3. Tertiary medical care

Tertiary medical care refers to highly complex and costly hospital care, usually with the application of advanced technology and multi-disciplinary specialized expertise. Tertiary medical care services are usually required by patients with complicated but relatively less common diseases or are suffering from catastrophic injuries or illnesses. Some examples of tertiary medical care services are organ transplants and radio-surgery of the brain including the use of Gamma Knife.

The public sector is the predominant provider of secondary and tertiary medical care in Hong Kong. Apart from general out-patient clinics (GOPCs), the Hospital Authority (HA) also manages all the public hospitals in Hong Kong. As at the end of 2006, there were 39 public hospitals with a total of 27,755 hospital beds, compared to 3,124 beds provided by 12 private hospitals.

Reference:
Your Health, Your Life — http://www.fhb.gov.hk/beStrong/

(B) Overview of the System

1. The Policy

“The Government aims to ensure no one in Hong Kong is deprived of medical care because of lack of means. It provides a wide range of public services and facilities to meet the healthcare needs of the community. It also works endlessly to safeguard public health – combating infectious diseases and promoting health education.” This declaration from the introduction in the Yearbook 2006 of Hong Kong Government outlines the mission of the healthcare system in Hong Kong.

In the ‘2007-08 Policy Address’, healthcare policy highlighted the following areas:

- Enhancing primary health care and promoting family doctor-based services
- Purchasing healthcare services from the private sector
- Exploring alternative models of public-private-partnership to facilitate integration of the public and private healthcare sectors, promote healthy competition for service quality and professional standards, and provide more choices for the public
- Developing medical centres in paediatrics and neuroscience to upgrade the healthcare services
- Developing a comprehensive strategy to prevent and control non-communicable diseases and enhance health education to improve the population’s health
- Strengthen the regulation of Chinese medicine, and enhance the integration of the Chinese medicine profession into the public healthcare system
- Developing a territory-wide, patient-oriented electronic health record.

2. The Structure

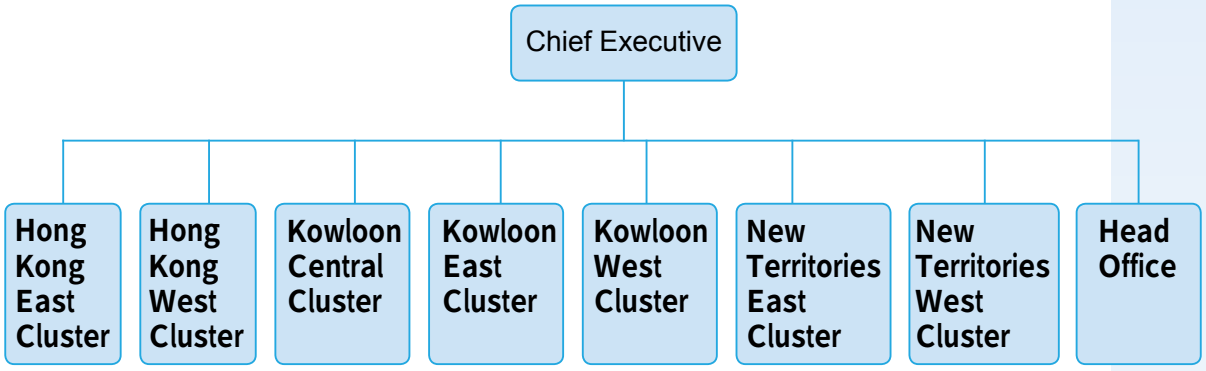
Policy Making	Food and Health Bureau	
Delivery	**Hospital Authority**	♦ Responsible for the delivery of medical treatment and rehabilitation services in Hong Kong. ♦ Responsible for managing publicly funded hospitals, specialist care and related services.
	Department of Health	♦ Responsible for safeguarding the health of the community through promotive, preventive, curative and rehabilitative services with four core roles, namely regulatory, advisory, health advocacy and promotion, and disease prevention and control. ♦ Responsible for providing a range of primary care, public health, rehabilitative and health promotion services.

3. Hospital Authority

Responsibilities	Under the Hospital Authority Ordinance, the Hospital Authority has the following responsibilities: ♦ Advising the government of the needs of the public for hospital services and of the resources required to meet these needs ♦ Managing and developing the public hospital system ♦ Recommending to the Secretary for Health, Welfare and Food Bureau appropriate policies on fees for the use of hospital services by the public ♦ Establishing public hospitals ♦ Promoting, assisting and taking part in education and training of HA staff and researching on hospital services

Financing	It is totally financed by government funding through taxation.
Structure	♦ The Hospital Authority is an independent organisation which is accountable to the Government through the Secretary for Health and Welfare, who is responsible for the formulation of health policies and monitoring the performance of the Authority. ♦ In 2008, it manages a Head Office, 41 public hospitals / institutions, 47 specialist outpatient clinics and 74 general outpatient clinics to deliver a comprehensive range of secondary and tertiary specialist care and medical rehabilitation; as well as some primary medical services.

The organisation structure can be found from the following organisation chart of regional clustering and managed by Cluster Chief Executives:



For more information about the Hospital Authority, refer to:
http://www.ha.org.hk

For more information about the Department of Health, refer to:
http://www.dh.gov.hk

(C) Overview of Medical and Health Services

Reference: Hong Kong Year Book
http://www.yearbook.gov.hk

1. Primary Healthcare Services

Primary healthcare is the first point of contact where individuals and their families are subject to a continuing healthcare process, which aims at avoiding hospitalisation and improving their health condition in general.

Clinic Services

Public general outpatient services of Hospital Authority are primarily targeted at low-income families, patients with chronic diseases and other vulnerable groups. The majority of Hong Kong people seek outpatient services from the private sector. Services are also provided by registered Chinese medicine practitioners and listed Chinese medicine practitioners.

Family Health

The Department of Health provides a comprehensive range of health promotion and disease prevention services through its maternal and child health centres and woman health centres for children up to five years of age, and women aged 64 or below. The government-subvented Family Planning Association (FPA) of Hong Kong offers comprehensive services and health information on sexual and reproductive health treatment and counselling through its various clinics, youth healthcare centres, women's clubs, and libraries.

Student Health

For primary and secondary school students, the Department of Health offers health assessment, health education and individual health counselling with emphasis on health promotion and disease prevention through its student health service centres and special assessment centres. To further safeguard students' health, school health inspectors pay regular visits to schools to check on their environmental hygiene and sanitation standards, while health officers and nurses provide advice on the control of communicable diseases. Teams from the Department of Health pay annual visits to primary schools to vaccinate students against communicable diseases.

Elderly Health

The Department of Health has set up elderly health centres and visiting health teams to enhance primary health care for the elderly, improve their ability to care for themselves, encourage healthy living and strengthen family support to minimise illness and disability of their elders. The elderly health centres provide people aged 65 or above with comprehensive primary healthcare services which include health assessments, physical check-ups, counselling, curative treatment, and health education. The visiting health teams conduct health promotion activities for the elderly and provide training for carers to enhance their health knowledge and skill in caring for the elderly.

Community Health

Community health service aims to minimise the needs for inpatient services by the public and facilitate patients' rehabilitation in the community. The service is provided by family physicians, community paediatricians, community physicians, general practitioners and community-allied health practitioners. The community health service also includes the community nursing services, community geriatric assessment, community psychiatric nursing services, and other community allied health services. Care-givers trained on the job in homes are permitted also to render community health services on a collaborative basis. The service provides medical support for the elderly who are discharged from public hospitals.

Volunteer groups have also been set up to help old people who have been discharged from hospitals. A telephone nursing consultation service has also been set up to provide home instructions and advice on disease management. There is also stationing of community nurses at care centres and non-governmental organisations to provide on-site care for people in the district. With regard to rehabilitation and palliative services, the hospital clusters under the ambulatory care centres are set up to take on discharged patients for short-term rehabilitation and an integrated palliative day care centre is started to provide a full spectrum of physical, rehabilitative, psychological and spiritual services to the patients and families in need.

Dental Health

The School Dental Clinics, run by the School Dental Service Division of the Department of Health, provide preventive dental services which include annual dental check-ups and basic dental care to primary students each year. The government dental clinics provide emergency dental services to the general public and there are also the specialist oral healthcare services in seven public hospitals to inpatients and others with special oral health needs. The Department of Health also monitors the level of fluoridation in water supplied to the public to reduce dental decay among people living in Hong Kong.

2. Secondary, Tertiary and Specialised Healthcare Services

Secondary, tertiary and specialised healthcare services are provided mainly in hospitals run by the Hospital Authority.

Specialist Outpatient Service

Secondary and tertiary ambulatory services in the public sector are provided mainly through the Hospital Authority's specialist clinics. At these clinics, patients' symptoms are assessed, and arrangements made for specific tests to be carried out to facilitate diagnosis, treatment, as well as follow-up treatment for patients who require long-term specialist care.

Most public hospitals have specialist clinics for internal medicine, surgery, as well as obstetrics, gynaecology, paediatrics, orthopaedics and traumatology, ear nose and throat, neurosurgery, oncology and cardiothoracic surgery. Many hospitals also have subspecialist clinics for cardiology, respiratory medicine, kidney disorders and other illnesses.

Acute Inpatient Service

Inpatient services are offered to patients who require intensive therapy for their acute illness. Supported by full ancillary services, clinicians in public hospitals are able to effectively treat patients with different medical needs through a comprehensive range of clinical specialities, including internal medicine, surgery, neurosurgery, clinical oncology, cardiology, obstetrics and other such operations and treatments.

Accident and Emergency Services

The hospitals provide service for people critically ill or injured who need urgent medical attention, or for victims of disasters. Since April 1999, patients attending the accident and emergency departments of public hospitals have been classified under five categories according to their state of health or injuries: Critical (Category 1), Emergency (Category 2), Urgent (Category 3), Semi-urgent (Category 4), and Non-urgent (Category 5).

Other Special Services

Physiotherapy	It is concerned with human function and movement, to maximize potential as well as to promote, maintain and restore physical, psychological and social well-being. Example: exercise for the back after occupational injury needs the advice from the physiotherapist.
Occupational therapy	To provide daily living skills evaluation and training, home modification to increase function and safety, education in use of adaptive equipment, and activities to promote upper-limb capacity. Example: rehabilitation exercise of fingers after industrial injury on upper limb to restore fine movement of fingers with advice from the occupational therapist.
Dietetic advice	To identify nutrition problems, assess the nutritional status of patients, develop care plans, monitor the effectiveness of dietary changes and provide dietetic advice regarding patients' health status. Example: the advice on the diet for patients of Diabetes.

(D) Alternative Healthcare Practices

1. Traditional Chinese Medicine (TCM)

In Traditional Chinese Medicine, the body is seen as a delicate balance of two opposing and inseparable forces: yin and yang, the concept of two opposing yet complementary forces described in traditional Chinese medicine. Yin represents the cold, slow, or passive aspects of the person, while yang represents the hot, excited, or active aspects. A major theory is that health is achieved through balancing yin and yang and a disease is caused by an imbalance leading to a blockage in the flow of qi (vital energy). In TCM, the vital energy or life force which is supposed to regulate a person's spiritual, emotional, mental, and physical health and to be influenced by the opposing forces of yin and yang along pathways known as meridians.

Chinese Medicine Council of Hong Kong
http://www.cmchk.org.hk

CUHK- Institute of Chinese Medicine
http://www.icm.cuhk.edu.hk

Hong Kong Jockey Club Institute of Chinese Medicine (HKJCICM)
http://www.hkjcicm.org

2. Acupuncture

Acupuncture is an alternative method of treatment which originated in China. It is a relatively painless treatment which involves the insertion of fine needles at specific points of the skin. Acupuncture has been found to enhance health and the immune system as well as addressing specific symptoms.

Practiced in China and other Asian countries for thousands of years, acupuncture is one of the key components of traditional Chinese medicine (TCM). The term "acupuncture" describes a series of procedures involving the stimulation of anatomical points on the body using a variety of techniques. The acupuncture technique that has been most often studied scientifically involves penetrating the skin with thin, solid, metallic needles that are manipulated by the hands or by electrical stimulation.

Acupuncture aims to restore and maintain health through the stimulation of specific points on the body called meridians. Qi can be unblocked by using acupuncture at certain points on the body that connect with these meridians. Sources vary on the number of meridians, with numbers ranging from 14 to 20. One commonly cited source describes meridians as 14 main channels "connecting the body in a web like interconnecting matrix" of at least 2,000 acupuncture points.

For further information, please refer to:
http://nccam.nih.gov/health/acupuncture

3. Naturopathy

Naturopathy, also called naturopathic medicine, is a whole medical system that originated in Europe. Naturopathy aims to support the body's ability to heal itself through the use of dietary and lifestyle changes, together with complementary alternative medicine therapies such as herbs, massage, and joint manipulation. This involves a whole medical system — one of the systems of healing and beliefs that have evolved over time in different cultures and parts of the world. Naturopathy is rooted in healthcare approaches that were popular in Europe in the 19th century, especially in Germany, but it also includes therapies (both ancient and modern) from other traditions. In naturopathy, the emphasis is on supporting health rather than combating disease.

The practice of naturopathy is based on some key principles:

- Promote the healing power of nature.
- First do no harm. Naturopathic practitioners choose therapies with the intent to keep harmful side effects to a minimum and not suppress symptoms.
- Treat the whole person. Practitioners believe a person's health is affected by many factors, such as physical, mental, emotional, genetic, environmental, and social ones. Practitioners consider all these factors when choosing therapies and tailor treatment to each patient.
- Treat the cause. Practitioners seek to identify and treat the causes of a disease or condition, rather than its symptoms. They believe that symptoms are signs that the body is trying to fight disease, adapt to it, or recover from it.
- Prevention is the best cure. Practitioners teach ways of living that they consider most healthy and most likely to prevent illness.
- The physician is a teacher. Practitioners consider it important to educate their patients in taking responsibility for their own health.

For further information, please refer to:
http://nccam.nih.gov/health/naturopathy/

10.3 Healthcare Reforms

(A) Ageing Population

The ageing trend in Hong Kong's population has continued during the past 10 years, with the median age rising from 34 in 1996 to 39 in 2006, according to the 2006 Population By-census results. Anticipating that the aging pace will accelerate in 2015 or 2016, about 27% of Hong Kong's population will reach the age of 65 or above in the 2030s.

At present, the size of the working-age population (aged 15-64) is larger than the population of children (those under age 15) and the elderly (over age 65). This demographic feature enables societies to spend relatively less, for example, on schools and old-age medical expenses and to invest savings for economic growth. However, it is expected that the dependency ratios will rise as the aged population inceases and the working-age population decreases.

(B) Dependency Ratio

The impact of population ageing is increasingly evident in the old-age dependency ratio, the number of working age persons (age 15 - 64 years) per older person (65 years or older) that is used as an indicator of the 'dependency burden' on potential workers. Between 2005 and 2050, the old-age dependency ratio will almost double in more developed regions and almost triple in less developed regions. The potential socioeconomic impact on society resulting from an increasing old-age dependency ratio is an area of growing research and public debate. In Hong Kong, the impact of population ageing is increasingly evident in the old-age dependency ratio, the number of working age persons (age 15 - 64 years) per older person (65 years or older), that is used as an indicator of the 'dependency burden' on potential workers. In Hong Kong, the ratio of our working age population to the elderly population is 6:1 in 2009, and will become 4:1 in 2020 and 3:1 in 2030. In the foreseeable future, there will be less and less young people who can help share the livelihood expenses (including medical expenses) of the elderly population.

(C) Expansion of Healthcare Expenditure and Services

The ageing population will accompany an increase in chronic diseases, and the strain on treatment, rehabilitative and relevant social services will also increase. For example, since the demand for hospital beds will increase with age, healthcare expenditure is expected to increase largely due to the increasing health needs of the ageing population:

2004 public health expenditure: about $38 billion

2015 projected public health expenditure: about $78 billion

2025 projected public health expenditure: about $127 billion

(Health and Food Bureau, March 2008)

According to the 2008-09 Budget from the Financial Secretary of Hong Kong, an ageing population definitely brings about an increase in demand for healthcare services. In 2008, nearly half of the total expenditure of the Hospital Authority is used to provide healthcare services for the elderly. The cost of providing such services to the elderly is on average six times that for other groups.

As people live longer, there is an increased demand for health and care related to chronic conditions such as cardiovascular and cerebrovascular diseases, malignant neoplasms, chronic obstructive pulmonary disease, osteoporosis and dementia. It is a fact that older individuals have a greater cumulative risk of chronic illness and disability requiring more intensive medical and rehabilitative services. As the ageing process of the population accelerates, an unstoppable rise in the proportion of the elderly is expected. Therefore, it is expected that the expansion of the health sector, especially geriatric specialty is unavoidable. For example, it requires more hospital beds, more advanced medical technology, more healthcare workforce particularly in gerontology and new insurance products.

As most of the elderly have retired and have lesser income, it is likely that in the future they will have to continue to rely heavily on the public sector for health. Since it is impossible for the government to increase public healthcare expenditure indefinitely, introduction of supplementary financing in parallel by various forms of financing package has been proposed to ensure the sustainable development of the healthcare system in the long run.

(D) Proposals on Reform

Hong Kong has a relatively simple healthcare financing system. Services provided by the public sector are financed almost entirely through general revenue. There are no national health insurance contributions or any other health related tax.

Services provided by the public sector include almost 90% of inpatient care, 15% of outpatient care, preventive and rehabilitative care. All Hong Kong residents are eligible to receive care, either free or at a heavily subsidized rate, from institutions under Department of Health or the Hospital Authority.

In the private sector, direct payment is the dominant mode of financing. As there is no public health insurance in Hong Kong, almost all the care provided by private practitioners is paid by individuals, employers or private insurance. Cross financing between the public and private sectors – i.e. public funds paying for services provided by private practitioners or private payment of services provided by public institutions - is minimal.

Because of the ageing population, increased medical costs and community expectation, the financial burden of the government healthcare system is increasing. The sustainability of the current healthcare system under the present policy of low-tax, high-subsidy and high-quality is being questioned.

There are different attempts to review and amend the mechanisms for financing healthcare services. Therefore, the government is making a new arrangement in reforming the healthcare system. Political Parties and Members of the Legislative Council have continuing debates on the healthcare financing models.

1. Healthcare Financing in Hong Kong

The following are features of the healthcare financing in Hong Kong:

<table>
<tr><td colspan="3">Tax-based financing system</td></tr>
<tr><td colspan="3">General taxation, Health insurance plans, Out-of-pocket payments</td></tr>
<tr><td rowspan="5">Share of financial responsibility</td><td rowspan="3">Hospital services</td><td>Individuals cover around 3% of the cost for public hospital services by out - of - pocket payments and / or health insurance.</td></tr>
<tr><td>Medical safety net to assist patients with financial difficulty in paying public hospital bills.</td></tr>
<tr><td>Fees and charges for private hospital services are covered by out - of - pocket payments and / or health insurance.</td></tr>
<tr><td rowspan="2">Primary healthcare services</td><td>Patients pay full cost for services in the private sector.</td></tr>
<tr><td>Patients who cannot afford private sector services can use subsidised public services.</td></tr>
<tr><td>Medicines</td><td>Patients are required to pay a small sum (HK$10) for each government - subsidized prescription except medicines provided during hospitalisation.</td></tr>
</table>

2. "Towards Better Health" (1993)

Five health financing models have been proposed in the consultation document "Towards Better Health" in 1993. They are:

Model of percentage subsidy approach	It is a restatement of the Scott Report recommendation that hospital inpatients should be charged a low percentage of the average bed-day cost, instead of a notional food cost. By these, three main types of hospital – acute general, convalescent/ infirmary, and psychiatric are subsidized at the same percentage.
Model of target group approach	It comprises two major elements – semi-private rooms and itemised charging – plus an option for waiver of charges. It aims to provide patients with a greater choice, while achieving greater equity in financing. Semi-private rooms promise a superior standard of accommodation for better-off patients who opt to pay a higher daily fee while itemised charging is an income based proposal.
Model of coordinated voluntary insurance approach	It involves the creation of a body to accredit medical insurance policies designed to cover treatment at public facilities. The idea is to increase consumer protection and transparency while involving relatively little government intervention in the industry.
Model of compulsory comprehensive insurance approach	It requires all households to participate in a centrally administered medical insurance scheme. Such scheme would cover primary and hospital care, up to a certain standard, in both the public and private sectors. Participants could also upgrade the level of coverage by purchasing supplementary insurance from medical insurance companies.
Model of prioritisation of treatment approach	This model seeks to overcome the problem of overloaded public facilities by listing medical conditions and treatments in order of priority and funding them in accordance with available resources. Patients with low priority medical conditions would simply not be treated, freeing resources and reducing waiting time for more important cases.

3. "Lifelong Investment in Health" (Harvard's Report) (1998)

After more than 5 years of debates on the above stated medical financing models, there was no consensus on implementing any of them. Therefore in 1998, another

consultation team - The Harvard Team - was appointed by the Government to examine the existing financing system and recommend changes. Besides maintaining the current financing system as one of the options, three other options were provided in the Harvard's Report. They are:

Cap the Government Budget for Health Care	Capping the government budget for health has many of the features of existing financing system. The only measure involved is setting an explicit upper limit on government healthcare expenditures (or a limit on the rate of growth of those expenditures).
User Fees	The aims of raising user fees for public facilities are twofold: to manage the government budget, and to reduce the overuse of nearly free public health services. The fee has to increase steadily to assure that government expenditure remains at a constant percentage of Gross Domestic Product (GDP). This option shifts the burden of increasing healthcare costs from the government onto households.
Health Security Plan and Long-Term Care Savings Accounts	This model consists of two separate components: mandatory contributions to individual savings accounts to be used to purchase long-term care insurance upon retirement or disability (MEDISAGE), and a Health Security Plan (HSP) for inpatient hospital and outpatient services for certain serious chronic diseases (The Harvard Team. 1998).

For further information on the proposal, refer to "Lifelong Investment in Health" from the following web site:

http://www.fhb.gov.hk/en/press_and_publications/consultation/HCR1.HTM

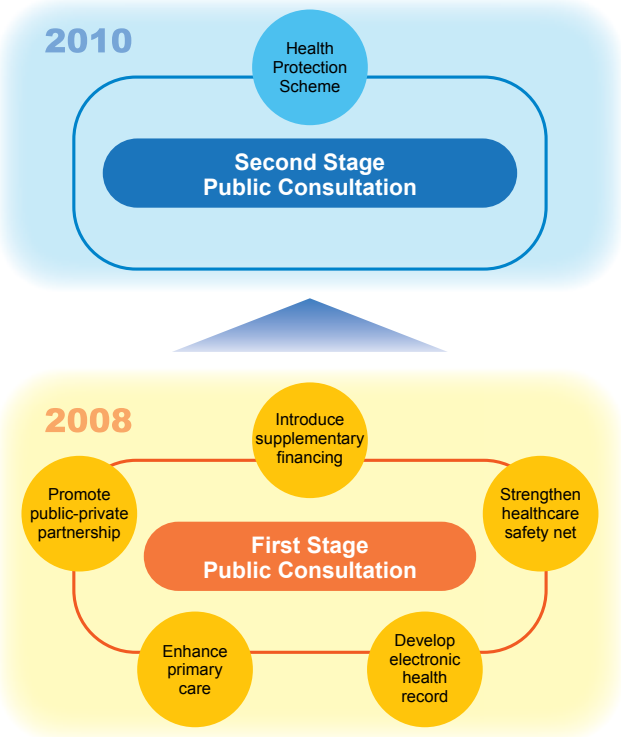
4. "Your Health Your Life: Healthcare Reform Consultation Document" (2008 and 2010)

In 2004, a paper on "Studies on HealthCare Financing and Feasibility of a Medical Savings Scheme in Hong Kong" was presented to the Legislative Council Panel on Health Services. Even though no consensus was made since then, discussion is going on. Until 2008, another healthcare reform consultation paper - "Your Health Your Life: Healthcare Reform Consultation Document" - is launched calling the discussion on the whole range of financing options. There are three models with six schemes in raising existing government funding to improve and sustain quality healthcare suggested in this consultation document. They are:

Tax-like Model	**Social Health Insurance**	All members of the working population are required to contribute a certain percentage of their income to finance healthcare protection for the whole population. All the contributions are paid into a social health insurance fund to provide subsides to the whole population for the use of public and private healthcare services covered by the social health insurance.
User-pays Model	**Out-of-Pocket Payments**	It needs to increase the user fees for using public healthcare services. With the exception of low-income and under-privileged groups, service users are required to share a larger portion of the costs for healthcare.
	Medical Savings	It requires a specified group of the population to deposit part of their income into a personal medical savings account to meet their own future healthcare expenses.
Individual Health Insurance Model	**Voluntary Health Insurance**	This option encourages members of the public to purchase private health insurance in the market voluntarily.
	Mandatory Health Insurance	It requires a specified group in the population to purchase individual health insurance regulated by the Government.
	Personal Healthcare Reserve	It requires a specified group in the population to deposit part of their income into a personal healthcare reserve account. Part of the deposit will be used for subscribing to a government-regulated personal healthcare insurance, and the remainder will be accrued in the account to continue subscribing the insurance and meet other medical expenses after retirement.

For details about the healthcare reform, please refer to the following website: http:// www.beStrong.gov.hk

2010 healthcare reform second stage public consultation



For further information, please refer to pelow website:
www.MyHealthMyChoice.gov.hk

(E) Health Financing Models in Different Countries

The models for health care in different countries can be classified as follows:

1. Market Orientated Approach

Allocation of resources will be done according to consumers' willingness to pay and privatisation of organisations that provides health services.

United States (USA)

- **Private Insurance**
  Until September 2009, a majority of the population relies on private insurance as their sole means of health care cover. Under such a system, the level of access to healthcare services is determined by the level of insurance cover which an individual can afford to purchase, and contributions are based not only on the ability to pay but also on an individual's health risk assessed by the insurer.

➢ **Medicare**

Medicare is a nationwide health insurance programme for the aged and certain disabled persons. The programme consists of two parts: Part A - hospital insurance (HI); Part B - supplementary medical insurance (SMI).

Medicare	Part A Hospital insurance (HI)	Part B Supplementary medical insurance (SMI)
Coverage	Almost all persons over the age of 65 are automatically entitled to Medicare part A. It provides coverage of inpatient hospital services, up to 100 days of post-hospital skilled nursing facility (SNF) care, home health services, and hospice care. Patients must pay a deductible each time their hospital admission begins. Medicare pays the remaining costs for the first 60 days of hospital care. A limited number of beneficiaries requiring care beyond 60 days are subject to additional charges. Patients requiring SNF care are subject to a daily coinsurance charge for 21-100 days .	Part B is voluntary. All persons over the age of 65 and all persons enrolled in part A may enroll in part B by paying a monthly premium. Part B provides coverage for physicians' services, laboratory services, durable medical equipment, hospital outpatient department services, and other medical services.
Financing	Part A is financed primarily through the HI payroll tax levied on current workers and their employers. Employers and employees each pay a tax of 1.45 % on all earnings, as in 2000. The self-employed pay a single tax of 2.9% on earnings, as in 2000.	Part B is financed through a combination of monthly premiums levied on programme beneficiaries and Federal general revenues. Beneficiaries' premiums have generally represented about 25% of part B costs; Federal general revenues account for the remaining 75%. (House Ways and Means Committee, 2000)

➢ **Medicaid**

Medicaid is the health program for eligible individuals and families with low incomes and limited resources. The Medicaid programme began in 1965. It is administered by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services and jointly funded by the states and federal government.

Medicaid aims to help low-income groups to pay for their medical expenses, which is different from hospital insurance in Medicare. Although both of them are health insurance, Medicaid provides health insurance to the low-income people of all ages whereas Hospital Insurance in Medicare is for individuals aged 65 and above or with disability.

The eligibility of individuals and families are determined by the states. Each state has its own requirements and procedures of application. If the applicants are receiving social security from the Social Security Administration, he/she is eligible for Medicaid. Generally speaking, it is provided for the low-income families, the disabled person in need of long-term care and the elderly in need of medical assistance and long-term care.

Medicaid does not pay money to the applicants. It directly pays the service providers. In some services, the applicants also need to pay a small proportion of the fee on their own.

2. Social medicine approach

Since health services are necessities for maintaining life and relieving suffering, everyone is entitled to reasonable access to health care, regardless of the ability to pay, e.g England, Canada.

England

Policy Making and Delivery	Policy Making	Department of Health.
	Delivery	Several types of statutory organisations (in particular strategic health authorities and primary care trusts) are responsible for providing or ensuring the provision of healthcare services in their respective geographical areas.

Healthcare Financing	Tax-based financing system. General taxation, national Insurance premiums, health insurance plans and out-of-pocket payments.	
Guiding Principles	To provide universal services for all people based on clinical need, not the ability to pay, because health care is a basic human right. To provide access to a comprehensive range of service through primary and community health care and hospital-based care.	
Share of Financial Responsibility	Hospital services	Public hospital services for eligible persons are free of charge unless they choose to be treated as private patients.
	Primary health services	Fully subsidized by public money, patients receive primary healthcare services provided by private medical practitioners free of charge.
	Medicines	Patients are required to pay a flat rate for each prescription. Owing to the exemptions granted to specific groups such as children and low-income families, around 85% of the prescription items dispensed are free to patients.
Policy Evaluation	Achievements	Faster accessibility to the National Health Services (NHS). Enhancement of the health status of the overall population. Increasing number of people adopting healthier lifestyles.
	Challenges	Deficit/overspending of the NHS organisations The National Audit Office and the Audit Commission recommend that the NHS financial regime should provide right incentives for best practice to enhance the quality of service and clinical productivity; and develop a more transparent financial reporting system to have an early identification of the financial problems of the NHS organisations and prompt reaction to the problems.

3. Mixed Mode Approach

Essential health services are available with reasonable access regardless of the ability to pay; but private health services are available to whoever could afford to pay or with insurance coverage, e.g Hong Kong, Australia.

Australia

Policy and Delivery of Health Care	Commonwealth government	Holds the overarching responsibility for making and administering nation-wide health financing policies. Administers healthcare financing schemes.
	State and territory governments	Formulates policies governing the delivery of healthcare services and regulation of health-related personnel and premises. Delivers healthcare services.
	Australian Health Minister's Conference	Offers a platform for health ministers of various levels of governments to discuss health policies and programmes.
Guiding principle	Facilitates universal access to health care while allowing choice for individuals through substantial private sector involvement in delivery and financing.	
Healthcare Financing	Type of financing system	Tax-based financing system.
	Funding sources	General taxation. Medicare levy. Health insurance plans. Out-of-pocket payments.

Share of financial responsibility	Hospital services	Public patients in public hospitals are free of charge. Private patients in either public or private hospitals receive 75% government subsidy on medical services and cover all other costs by out-of-pocket payments and/or health insurance.
	Primary healthcare services	Patients receive government subsidy to cover 85% of the cost on private out-of-hospital services and the remaining 15% is covered by out-of-pocket payments but not by health insurance. Medical safety net will provide assistance to those patients with difficulty in handling payments.
	Medicines	Patients are required to make a co-payment for acquiring government-subsidized prescription medicines. Pharmaceutical safety net will assist patients in making the co-payment.
Policy Evaluation	Achievements	Increasing private sector involvement in the delivery and financing of healthcare services. Increase in the take-out rate of health insurance.
	Challenges	Corresponding increase in government expenditure on rebate. Higher-income households receiving a larger rebate. Lack of incentive for insurersto manage high-cost cases cost-efficiently.

(F) Public and Private Sectors and their Roles in Healthcare Services

Some professionals in the healthcare sector expect that the healthcare reform will encourage more patients to use the private services in order to reduce both the financial and workload burden on the public sector. In the healthcare reform, the competitive but complementary roles between the public sector and the private sector are under discussion.

1. The role of the public sector

✎ Disseminations of health information

Many health and social services such as information and control of contagious diseases are for public good. One person's use of health information does not make it less available for others to consume. For example, one person can not benefit from the control of infectious disease, does not exclude another person from benefitting. Therefore, the public sector is responsible for delivering information to the public by encouraging behaviours that carry positive impacts on public health and to discourage those with negative impacts.

✎ Ensuring function of safety net for the disadvantaged groups

Provision of health services to the poor is a socially acceptable approach to poverty reduction. Private markets will not give the poor adequate access to essential care. Therefore, public finance of essential health care is justified to alleviate poverty. It can be in the form of free delivery services, or below-cost public services, or provision of subsidies to private providers and non-governmental organisations that are voluntary non-profit making but are willing to serve the poor.

✎ Protecting consumers through regulation, education and information

A healthcare system based purely on market mechanism is likely to fail to efficiently provide the population with sufficient quantity of services and quality of care. Markets work best when information about goods and services are readily available and producers and consumers are equally well informed. In certain circumstances, many users of care services are

poorly educated: these users have difficulties in gauging the substantive quality and the appropriateness of the care they receive. Under these informational conditions, service providers of the private sector may have the incentives to provide lower quality of service, inappropriate types of care, non-efficacious care, and charge a higher price to the services provided. As a result, institutional responses can be explored and the government should take the lead in such situations. These responses include regulation, education and information for consumers to make efficient choices of the public provisions of health and social services.

Advocating equity in accessing health and social care services

The public sector plays a key role in attempting to achieve equity as it is a very important societal objective. This is the reason why both finance and delivery of services have been taken up by the public sector particularly in areas where demand is insufficient to stimulate private provision.

2. The Role of the Private Sector

Complementary roles from private sector

As a developing city seeking to pursue human resource development vigorously through expansion of services, including education, health, welfare, family, housing programmes, it will be increasingly difficult for government to organise, finance and deliver these services in sufficient quantities and high qualities to meet population needs within a short period of time. Resource constraints in the healthcare sector is particularly acute as expanding economics continue to put upward pressure on the prices of pharmaceuticals, medical technologies, and the wages of trained health and social personnel making it increasingly costly to procure these services, train and retain manpower. It is the time to seek complementary roles from the private sector so that public sector resources can be more efficiently used to achieve other social goals.

Acting as a valuable distribution channel for priority services

In many countries private sectors are the primary care provider for large segments of the population, and thus they are a valuable distribution channel for priority services. For example, most countries undertaking health sector reform generally seek to improve equity, access, quality, efficiency, and sustainability of care services. From the following perspectives, private sectors may have advantages over the public sector in assisting the government to achieve these objectives:

- Equity: It is considered the private sector encourages higher income segments of the population to use their services. It can contribute to equity by freeing up government funds that can be used to provide priority services to segments of the population that cannot afford to pay.

- Access: Private providers may be located in areas convenient and may be available during more convenient time for the service recipients. It increases the accessibility of services.

- Sustainability: The private sector can contribute to sustainability by creating an open market for health and social services, independent of changes in government policies and budgetary constraints.

For further information on the role of different sectors in healthcare system, refer to the following web link:

http://www.hkdf.org/papers/9310health.htm

10.4 Conflicting Agendas in the Healthcare Reform

There are some conflicting agendas behind the healthcare reform. They include:

(A) Private-public Debates and Tensions

1. Supports For: Service Provided by Public Sector

Traditionally, healthcare markets in Hong Kong were rejected in favour of a tax-funded public service, which allocated resources according to needs. The provision of the services is not dictated by market but by needs and the availability of resources. There is a debate in putting health care in the private market because it represents the public benefits. It is believed that the benefit of any healthcare intervention is not only experienced by the individual receiving it but also by society at large. In other words, in providing health care, the government is pursuing social goals that profit-seeking, market-oriented, private sector organisations overlook or play down.

These social goals include:

- **Social Stability**
  (1) avoiding inequality along health lines and the consequent social resentment;
  (2) removing anxiety associated with health costs.
- **Efficiency**
  (1) primary healthcare and disease prevention contributing to the good health of the next generation;
  (2) ensuring that ill health does not undermine the ability of people to fill their social roles as parents and citizens.
- **Safety**
  protecting people from diseases and the fear of diseases, minimizing potentials for epidemics.

2. Support For: Service Provided by Private Sector

Private sector healthcare services refer to organisations that are privately owned and work on allocating goods and services on the basis of willingness and ability to pay. Within this context, the private sector of health and social care serves to:

- extend consumer choice
- reduce waiting list
- increase efficiency
- improve the costing and pricing of treatments or services
- inject new ideas
- release the financial tension of government as it shares some of the services that can be afforded by those customers willing to pay

3. Opinions against Private Sector

- Some consumers may have more choices about the service providers, e.g which doctor to see or which hospital to attend, but they lack the information and expertise to make informed choices.

- Poorer consumers will have no choice at all, e.g. the majority of the ageing population is poorer consumers as they cannot generate income, they may not be able to afford private care for the aged.

- With respect to efficiency, there is little evidence to support the view that the private sector is better than the public.

- If the healthcare systems are dominated by the private sector, they may become fragmented, poorly planned and badly coordinated

- Monitoring quality in the private sector is also a challenge. To maximize profit, services produced in the private sector may be operated at a lower workforce ratio to reduce the cost. This may affect the quality of services provided.

Nevertheless, the future provision of health care is likely to be based on the involvement of both sectors, public and private, to offer more choices for customers. However, the market share is various between countries as it is determined by other factors such as socio-economic and political climates.

(B) Private vs. public responsibility

On the one hand, due to the core value of the obligation to care for others in the Chinese culture, the obligation to provide care for the vulnerable creates the voices for urging Government to put greater efforts to provide medical care for the sick, care for the elderly or disabled, or even financially supporting those who cannot earn enough to live. However, on the other hand, an increasing demand on health and social care services due to a progressively ageing population contributes to the increasing cost in health care. Some people think that Government should protect the deprived groups by providing public services at an affordable price and at the same time adopt mechanism to ensure those who can afford to take up their responsibility in paying the health and care services. Thus, increased user charges or how much to be raised then becomes the agenda to be debated. The key question is: what are the personal and government roles on health care? The limits and priorities of the public aspirations may need to be debated, too.

(C) Financing principles – percentages to be paid by users and tax payers

According to the Government's Domestic Health Accounts, Hong Kong's health bill increased from 3.8 per cent of GDP in 1989-90 to 5.5 per cent in 2001-02. The Government's share of this expenditure rose from 43 per cent to 57 per cent in the same period. The Government's total spending on health-related matters in the 2004-05 financial year amounted to $37.8 billion, equivalent to 14.7 per cent of total public expenditure, or 2.9 per cent of GDP. Based on these expenditures, the Government experiences a challenge of long term financial sustainability with the existing taxation system.

While investigating the present financial pressure on the public health system, most people may agree that the present financial problem has arisen because of our current financing structure. The huge subsidy invested in the system, plus the improving standards, have not only attracted those who cannot afford to the public sector, but also a substantial number of patients who can afford to pay more. From the tax payers' point of view, it is reasonable to use the public healthcare services no matter how much they are taxed. So in financing principles, it raises the question on reforming the current financing arrangements to provide supplementary financing as stated in "Your Health Your Life: Healthcare Reform Consultation Document" from Food and Health Bureau, HKSAR Government in 2008.

(D) Priorities of Resource Allocated to Related Parties and Organisations

Hospitals are the dominant institutions providing health care in Hong Kong. Priority is given to hospital-based services for the past decades instead of across different types of services, such as primary health care, health education and health promotion, etc. It has been critiqued that the Hospital Authority is staffed almost completely for specialty service. This means that priority and resources are drawn away from primary care and community medicine, which will become increasingly important in managing the growing number of chronically ill patients as the elderly population increases.

(E) Cost-Effectiveness vs. Clients' Satisfaction

Cost-Effectiveness
Cost effectiveness can be achieved by the procedures which monitor and review how organisations work in terms of financial prudence and resourcing.

In the past colonial days of Hong Kong, it was easy for the Government to operate in a benevolently paternal fashion providing healthcare services which the bureaucrats think people need rather than the services which people actually want. However, with economic growth and in line with an international trend, Hong Kong's healthcare services have come under increasing scrutiny during the past decade. It is not surprising that people term healthcare services as goods and evaluate these services from the consumers' point of view after a long-time advocacy of the consumers' rights movement. In the new millennium, people are more vocal about what they expect of health and social welfare in Hong Kong. As Hong Kong residents become more affluent and educated, they demand higher quality of services, such as better facilities and amenities, shorter waiting time, more high-tech diagnostic tests and drugs, which are all costly to provide. However, since resources are limited, cost-effectiveness and clients' satisfaction is always a conflicting agenda between the service providers and clients. How to make trade-offs in the healthcare system when pursuing multiple goals, such as equity, efficiency, quality and cost control remains a problem for the policy makers nowadays.

To meet the challenges outlined above, one of the solutions is to change the positioning of the public and private sectors. Almost all tertiary and specialized services at present

are provided at highly subsidized rates in public hospitals. The Government could encourage local collaborations among the public medical sector and the private medical sector to help in meeting the demand. This model with a re-alignment for roles between the two main service providers of the healthcare system is an alternative to ensure that limited resources are being utilized in the most appropriate manner and for those in genuine need of such services, at the same time, providing more choices for the clients.

(F) Example of Collaboration between Public and Private Sectors - Cataract Surgeries Programme

As the number of patients waiting to receive cataract surgery in public hospital is increasing, the average waiting time for surgery is about 3 years. In order to solve the problem, the Cataract Surgeries Programme is a government-funded programme to increase the cataract surgeries output through a public-private partnership delivery model. That is, Hospital Authority will provide a one-off maximum subsidy of $5000 to the patient for cataract surgery provided by private ophthalmologists. Such patients may need to co-pay for the private ophthalmologist's fee. This model serves a complementary role between the public sector and the private sector as well as competitive role amongst service providers of the private sectors; and between the private and public sectors as this provides more choices for the patients.

For more information about the Cataract Surgeries Programme, refer to:

Hospital Authority: http://www.ha.org.hk

Path: Public Private Interface
→PPI Initiatives
→Cataract Surgeries Programme

Learning and Teaching References

1 Personal Needs and Development across Lifespan
2 Health and Well-being
3 Physical Well-being – Healthy Body
4 Mental Well-being – Healthy Mind
5 Social Well-being – Inter-personal Relationship
6 Healthy Community
7 Caring Community
8 Ecology and Health
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