Medical Stakeholders' Opinion Research on Health Protection Scheme – Postal Survey

Final Report

Prepared for

Food and Health Bureau

The Government of the Hong Kong Special Administrative Region

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June 2011

Table of Contents

Executive Summary

As part of the Government's deliberating process of the Health Protection Scheme (HPS), the Food and Health Bureau commissioned the CUHK School of Public Health and Primary Care to collect and analyse the views of stakeholders from the medical sector on the proposed HPS and its related measures. Both quantitative method, a cross sectional questionnaire survey, and qualitative method, focus group discussions, were adopted in the study. This report and the executive summary highlight the major findings from the questionnaire survey.

We conducted a mail survey among all western medical practitioners registered with the Medical Council of Hong Kong between February and April, 2011. Findings presented here are based on 1,100 responses, a sample resembling known distribution of western medical doctors according to the 2009 Health Manpower Survey conducted by the Department of Health.

Awareness about the HPS and healthcare reform

Responding doctors' awareness about the HPS was more or less evenly distributed (ranging from "not aware or comprehend at all" to "comprehend 100% of its content"), with 57% doctors comprehending 50% or more of the HPS content. However, 63% respondents, despite their awareness that the HPS is only part of a comprehensive healthcare reform package, did not know what the other reform components are or the details of each component.

Views on performance and coverage of current health insurance market

More than half of responding doctors expressed concerns over the inadequacy and inefficiency of current health insurance market. 53% responded that the current health insurance market does not offer enough coverage for common treatments in private hospitals, while 61% responded that the incidents of insurance abuse, such as charging according to benefit limit, was non-negligible. When asked about the priority of covering various components in a private health insurance policy, the large majority (72%) ranked hospital admissions as the most important benefit to be covered by private health insurance, followed by ambulatory procedures (42%). However, less consensus was reached for covering primary care in general: roughly one-third of General Practitioners (GPs) (32%) or family medicine (FM) specialists (33%) ranked it as a potential top priority, while non-FM specialists tended to rank it much lower.

Diagnosis-related groups (DRG)-based charging

Doctors' views on the feasibility of DRG-based charging varied somewhat in different contexts, as we varied the specific components to be included. Generally speaking, slightly over half of respondents (51%) agreed that it is feasible for providers to set charges for common treatment based on DRG, as compared to 28% who were neutral and 21% who disagreed. The levels of agreement and disagreement increased slightly to 53% and 23% respectively if the application of DRG-based charging is limited to hospital charges alone. If DRG-based charging applies to all charges, the level of agreement (37%) was slightly lower than the level of disagreement (39%). If DRG-based charging applies to doctor fees alone, the level of agreement (29%) was much lower than the level of disagreement (43%).

Compared with GPs/FM specialists, non-FM specialists considered DRG to be feasible for a higher percentage of their own work cases. In particular, 45% of public non-FM specialists thought it is feasible for half or more of their cases, whereas only 21% private GPs/FM specialists thought so.

Roughly 70% of responding doctors agreed that the DRG-based charging would increase transparency, competitiveness and certainty of private healthcare charges. However, 56% of respondents worried that DRG-based charging would reduce professional autonomy of private doctors. In addition, in almost all DRG-related questions, we found more than 20% respondents and occasionally nearly 50% had "neutral" views, possibly due to limited market experience with this charging method in Hong Kong so far.

Overall, DRG-based charging seemed to have attracted higher support among public doctors than private doctors. The difference is less clear when comparing GP/FM specialists with non-FM specialists.

Regulatory measures

Doctors were asked about eight different regulatory measures that the Government would consider to use for support of HPS and promotion of healthcare system development. For all but two measures, the agreement rate reached more than 60%. The highest rate (73%) was seen for improving collection, collation and dissemination of data associated with patient care and outcomes; the lowest (33%) seen for enhancing lay representation on the Medical Council. Again, public doctors expressed stronger support for most of these regulatory measures.

Government incentives

All the financial incentives proposed by the Government to encourage HPS enrollment gained agreement from over 69% of responding doctors, with tax concession for HPS premium getting the highest agreement rate (81%).

Infrastructure and manpower

Unlike regulatory measures and Government incentives, measures for infrastructure development had varying degrees of agreement among responding doctors. They expressed strong opposition to attracting qualified specialists trained in Mainland China to practice in Hong Kong (56% disagreed to the measure). On the other hand, increasing the number of beds in existing private hospitals or increasing the number of private hospitals both got more than 70% agreement rate (77% and 74%, respectively). Notable difference was seen between public (59%) and private (45%) doctors in their opinions on increasing the local doctor-training quota.

Agreement on HPS objectives and impacts

About 60% of responding doctors agreed or strongly agreed with the objectives of HPS. Slightly over half (53%) saw positive or very positive long-term impact of HPS on the development of Hong Kong's healthcare system. In particular, public doctors (58%) felt more positively about HPS's general impacts, compared with private doctors (48%).

In summary, the general design of HPS and its related regulatory measures and Government incentives received support from the majority of responding doctors to our survey. However, some of the more technical design features, in particular, DRG-based charging, received divided opinions. In addition, there were some questions, usually the more technical ones, which draw a considerable degree of neutral responses. This may reflect that for various reasons, such as heavy workloads on hand and complexity of the issues involved, some doctors may not be able to keep track with the progress of the ongoing healthcare reform or establish knowledge on specific features to the extent that they feel comfortable in rendering their opinions.

摘要

政府最近建議推行醫療保障計劃（醫保計劃），作爲就有關決策過程中的其中一個環節，食物及衞生局委托香港中文大學公共衛生及基層醫療學院收集和分析各醫療界持份者對醫保計劃及相關措施的意見。本研究以定量及定質兩種方法進行，分別使用了橫斷面問卷調查及專題討論的形式收集意見。本報告及摘要會重點闡述問卷調查的主要結果。

在二零一一年二月到四月期間，我們向所有於香港醫務委員會註冊的西醫郵寄了一份調查問卷。最後樣本共包括一千一百個回應，其專業背景分佈與衞生署進行的二零零九年醫療衞生服務人力統計調查中得出的分佈相似。

對醫保計劃及醫療改革的認識

就對醫保計劃的認識，有回應的醫生的答案分佈頗爲平均（包括從「完全不認識或不理解」到「100%理解所有內容」），當中 57%的醫生表示能夠理解醫保計劃內容的一半或以上。然而，63%的回應者表示，儘管他們意識到醫保計劃只是整體醫療改革的其中一個項目，他們並不清楚其他醫療改革項目或每個項目的詳情。

對現時醫療保險市場的表現和保障範圍之意見

超過一半作出回應的醫生認爲現時醫療保險市場提供的保障和發揮的功能有不足之處。53%的回應者認爲，現時醫療保險市場未能充份就私營醫院所提供的常見治療提供足夠保障。此外，61%的回應者認爲濫用保險的事故，如根據保險賠償上限收費等情況，並非罕見。當被問及不同保障項目於私營醫療保險的重要性，絕大部份回應者(72%)將住院治療列爲私營醫療保險中最重要的保障項目，其次是非住院手術(42%)。在基層護理方面則較難達到共識，約三分一的普通科醫生(32%)和家庭醫學專科醫生(33%)將基層護理列爲最重要的保障項目，但非家庭醫學專科醫生普遍傾向將基層護理排在較次要的位置。

按症候族羣分類釐定套餐式收費模式

對於按症候族群分類釐定套餐式收費之可行性，有回應的醫生在不同的假設處境下，其取向有些不同。總體而言，超過一半回應者(51%)同意由服務提供者按症候族羣分類爲常見治療訂定收費的做法是可行的，另外有 28%表示中立，而 21%則表示反對。若按症候族羣分類釐定套餐式收費模式只限於醫院收費，表示同意和不同意的比率分別稍增至 53%和 23%。若有關模式用於所有收費，表示同意的比率(37%)則略少於不同意的比率(39%)。若按症候族群分類釐定套餐式收費模式只限於醫生收費，同意者的比率(29%)則遠低於不同意者的比率(43%)。

相對於普通科醫生或家庭醫學專科醫生而言，非家庭醫學專科醫生認爲按症候族羣分類釐定套餐式收費的模式在他們自己的工作個案中較爲可行。45%的公立非家庭醫學專科醫生認爲，在他們自己的工作個案中，有一半或以上可按症候族羣分類釐定套餐式收費。反之，只有 21%的私家普通科醫生或家庭醫學專科醫生有相同意見。

約有七成作出回應的醫生同意按症候族羣分類釐定套餐式收費模式能夠提高私營醫療收費的透明度、競爭力及明確性。然而，56%的回應者擔心按症候族羣分類釐定套餐式收費會削弱私家醫生的專業自主權。此外，在所有與症候族群分類相關的問題中，我們發現超過兩成及偶爾近五成的回應者表示中立，這可能是由於這種收費模式目前在香港累積的市場經驗有限。

總括來說，似乎公立醫生比私家醫生較支持按症候族羣分類釐定套餐式收費，但有關差異在比較普通科醫生或家庭醫學專科醫生和非家庭醫學專科醫生的意見時，則相對不明顯。

監管措施

我們就八項政府考慮用以配合醫保計劃及促進醫療系統發展的監管措施，通過問卷收集了醫生的意見。除了兩項措施以外，其他六項措施均得到超過六成回應者的支持。其中以搜集、核對及發佈與病人護理和醫療成效相關資料的支持度最高(73%)，支持度最低的一項爲增加香港醫務委員會的業外代表(33%)。此外，我們發現公立醫生對大部份監管措施都有較高的支持度。

政府提供的誘因

就政府建議提供財務誘因以鼓勵市民參與醫保計劃，作出回應的醫生對所有問卷提供的財務誘因可能方法的支持度均超過 69%，當中爲醫保計劃保費提供稅項寬減的建議獲得最高的支持率 (81%)。

醫療基礎設施及人手

有別於對監管措施和政府提供的誘因，作出回應的醫生對問卷提供的醫療基礎可能設施及人力規劃可能措施持有不同的支持度。他們對引入於內地受訓的合格專科醫生來港執業的方法表示強烈反對（56%不同意這項措施）。另一方面，超過七成醫生支持增加現有私家醫院的病牀數目(77%)或私家醫院數目(74%)。對於增加本地醫生培訓名額，公立醫生(59%)和私家醫生(45%)的支持度則存有一定距離。

醫保計劃的目標和影響

近六成回應的醫生同意或非常同意醫保計劃的目標。略多於一半(53%)的醫生認爲醫保計劃對香港醫療系統的發展有正面或非常正面的長遠影響。當中公立醫生(58%)較私家醫生(48%)有更大比例認爲醫保計劃會帶正面或非常正面的影响。

總括而言，醫保計劃的整體設計、相關的監管措施，以及政府提供的誘因在是次調查中得到大部份作出回應的醫生支持。不過，在部份技術性較高的細節上，尤其是按症候族羣分類釐定套餐式收費，意見則不一。此外，在某些問題上，通常也是較爲富技術性的問題，有相當大比例的回應者表示中立。這情況可能反映因爲牽涉的問題較複雜，以及回應的醫生本身公務繁忙，以致部份醫生未必能對現時醫療改革的進程或對建議的具體細節，有足夠時間作出充分了解和回應。

1. Background and Objectives

The Government published the second stage public consultation document on healthcare reform on 6 October 2010, under which a government-regulated, incentivized, voluntary Health Protection Scheme (HPS) is proposed. The HPS aims to enhance transparency, competition and value-for-money in the private sector, thereby providing more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services. It also aims to ease the pressure on the public healthcare system and better enable people with health insurance to stay insured. The Government will consider using the $50 billion set aside from the fiscal reserve to encourage the public to participate in the HPS.

In addition to the consumers, hospitals and doctors are also likely to be affected by the implementation of HPS. To collect the views of stakeholders from the medical sector on the proposed HPS as set out in the consultation document, the Food and Health Bureau (FHB) commissioned the School of Public Health and Primary Care, the Chinese University of Hong Kong in December 2010 to conduct a study that would generate both quantitative and qualitative analyses regarding their comments, concerns and suggestions about the HPS. The findings are expected to provide useful reference for the Government in further deliberating the HPS. This document summarizes key findings from the quantitative analyses based on a mail questionnaire survey among all registered western medical doctors (WMDs) in Hong Kong. Qualitative analyses of focus group discussions are presented separately.

More specifically, the key objectives of this survey study were to collect and analyze the views of medical stakeholders on (1) the healthcare reform direction proposed in the second stage public consultation; (2) the HPS in general, including its underlying concepts and principles, stated objectives and basic structure, particularly the introduction of a benefit structure based on Diagnosis-Related Groups (DRG); (3) the appropriate regulatory measures and Government incentives that can better enable the HPS to function effectively; (4) the appropriate strategy and planning in healthcare infrastructure and manpower resources; and (5) other possible measures that can promote the healthy development of the healthcare system and medical sector.

2. Survey Methodology

2.1 Survey Subjects and Mailing Strategy

The survey was sent to *all* western medical practitioners listed in the up-to-date registration obtained from the Medical Council of Hong Kong on 23 December, 2010. In total, questionnaires were mailed to 11,890 doctors (unduplicated count), whose names were listed in full registration (resident list only), limited registration, or specialist registration. In other words, non-residents, those with only provisional registration or temporary registration were excluded.

An accompanying cover letter on university letterhead explaining the purpose of the study and an assurance of confidentiality was enclosed with the questionnaire, together with a prepaid, business reply, self-addressed envelope to facilitate reply of completed questionnaires. Up to three reminders were arranged for initial non-respondents. The first reminder letter and a copy of the questionnaire were sent to those who have not responded after 14 days (the second mailing). Similarly, a second reminder (the third mailing) was sent out after another two weeks, followed by a final reminder to reach some (but not all) non-respondents through telephone calls. The limited number of final reminders was due to lack of telephone numbers from the registration list provided by the Medical Council. We had to rely on the incomplete list of doctors from www.hkdoctors.org, a website maintained by the Hong Kong Medical Association, to obtain contact information provided by doctors themselves voluntarily.

2.2 Questionnaire

Following objectives set forth previously, the questionnaire was divided into three sections: (1) awareness about the HPS and the ongoing healthcare reform in general; (2) views on health insurance, specific HPS design features (including DRG-based charging) and supporting measures (including regulatory measures, government incentives and manpower development measures), as well as overall impact of HPS; and (3) demographic and practice-related details of respondents (such as age, sex, full- vs. part-time, specialty, work nature, public vs. private sector, and medical degree). The final questionnaire is enclosed in Appendix I for reference.

Ethics approval for this study was obtained from the Ethics Committee of the Faculty of Medicine, the Chinese University of Hong Kong.

2.3 Fieldwork and Response Rate

Before the commencement of the fieldwork, a pilot test of the questionnaire was conducted in late January among 26 doctors to test the survey logistics and flow of the questionnaire. After several rounds of discussion with the FHB and based on feedback from the pilot test, modifications were made to the questionnaire.

Due to the large volume and holiday schedule, the first mailing of final questionnaire took place during 7-15 February, 2011, followed by the second mailing (completed on 3 March) and the third mailing (completed on 18 March). The final telephone reminder was placed in April to 2,586 non-respondents, whose telephone numbers were available.

As of 12 May, 1,100 completed questionnaires were received, representing a response rate of 9.4% (denominator excludes 153 undeliverable cases such as moved or invalid address). As we show next, despite a relatively low response rate, the final sample size had big enough power to detect differences between key subgroups. In addition, when possible, calculation of Cohen's effect size also demonstrates that the demographic and other relevant profiles of our survey respondents were generally consistent with the findings in the 2009 Health Manpower Survey conducted on all local practicing physicians by the Department of Health (DH), the only data source available to compare the distribution of our respondents to.

2.4 Data Processing and Analysis

Given the lack of control totals that represent the full universe of local doctors, and the similar demographic and other relevant profiles between our survey respondents and DH's, validated but un-weighted data were analyzed using descriptive statistics and comparison of proportions. Before any data analysis, all data entries were double checked by different individuals and validated using pre-set rules. For various reasons, respondents may have skipped or refused to answer certain questions. We considered these unanswered questions missing data (which is different from those who checked "don't know", an option sometimes provided as a valid answer). For most questions, we had less than 2% missing data (see appendix II for more details). To avoid misinterpretation of findings, all tabulations of responses throughout this report excluded these missing data.

The primary outcome measures were based on questions from the first two sections of the questionnaire, most of which were asked on a likert scale. They were then cross-tabulated with independent background variables captured in the last section of the questionnaire for subgroup analysis. In particular, we

focused on key groups of doctors defined by workplace (question 3b) and specialty (question 3c), as we expect they may have different views on those HPS design features that are more technical and closely related to their individual work experience (e.g. DRG-based charging). More specifically, we grouped responding doctors into five mutually exclusive workplace/specialty categories: (1) General Practitioners or Specialists in family medicine, who are working in private clinics or hospitals (i.e. Private GPs/FM Specialists); (2) Private non-FM Specialists; (3) Public GPs/FM Specialists (including those working in Hospital Authority, Government Departments or universities); (4) Public non-FM Specialists; and (5) Others (such as trainees and retirees).[1]

The chi-square test was employed to test for the significance of the difference between subgroup proportions. Unless otherwise noticed, percentages were calculated excluding missing data and the statistically significant level was 5%. SPSS (Statistical Package for the Social Sciences software) was used for data analysis.

2.5 Study Limitation

Although the survey was conducted among all registered western medicine doctors in Hong Kong (as opposed to a random sample), the low response rate undoubtedly limits the interpretation of the results. Readers should take caution, especially when examining the sub-group analysis, as the number of respondents gets lower in each group. Compared with DH's 2009 health manpower survey (which was a voluntary survey itself with a response rate of 69.8%), the demographic and other relevant profiles of our survey respondents showed similar patterns. However, it is impossible to determine whether we had a representative sample, especially with possible non-response and selection biases. For example, doctors who had more knowledge or felt more strongly (whether positive or negative) about the HPS might be more likely to return the questionnaire.

Only English questionnaires were used for the survey, which might have discouraged some doctors who were more comfortable with Chinese from

[1] Because Questions 3b (workplace) and 3c (specialty) allowed multiple answers, we created mutually exclusive subgroups under each question, before combining them into the 5 workplace/specialty categories. We assumed certain priority setting to do so. For question 3b (workplace), if the respondent chose one of the private options, regardless of what else he/she chose, he/she was categorized as working in the private sector; or else, if the respondent chose the Hospital Authority or universities option, he/she was categorized as working in the public sector; only those who chose "others" alone were categorized as "others". Similarly, for question 3c (specialty), we categorized respondents who chose specialist-clinical or specialist-nonclinical as "non-FM specialist", those who chose specialist-family medicine and general practitioner as "GP/FM Specialist"; and the rest as "others".

responding. In addition, due to the limited questionnaire space and the complexity of HPS itself, many terms were not specifically defined, therefore might have left room for different interpretations by the respondents. Readers should pay attention to the “neutral” responses as well as the agreement or disagreement responses.

3. Major Survey Findings

We present major findings based on quantitative analysis of survey responses to each question, overall and for key subgroups. When differences by workplace/specialty are statistically significant, we included a separate discussion under each question. Chi-square test results of all the other subgroup analyses are summarized in section 3.5 at the end of the report.

3.1 Respondents' Profile

Respondents' demographic and practice-related background information are summarized below, and when possible, compared with findings from DH's 2009 Health Manpower Survey.[2] Of responding doctors who provided answers to the corresponding question,

- 20% were aged 30 or below, 14% aged 31-40, 28% aged 41-50, 19% aged 51-60 and 19% aged 60 or above (Q3g).
- 73% were male, similar to that reported by DH's survey (Q3f).
- 88% were working full-time, 7% were working part-time and 5% were not actively practicing (Q3a).
- Almost half (46%) were working in the public sector (including Hospital Authority or Government departments), again similar to that reported from DH's survey. Another 44% were working in private clinics, 10% in private hospitals, and 5% were working in universities (Q3b).[3]
- Among those working in the private sector, the large majority (69%) worked as solo practitioners in the private sector, 13% and 11% were engaged in group practice as non-partner and partner, respectively. Another 4% worked as resident doctor in private hospitals (Q3e).
- 28% identified themselves as General Practitioners, whereas 65% as specialists (including 6% in family medicine) (Q3c).
- When the highest proportion of time spent on specific nature of work was identifiable (some distributed time evenly), 34% reported spending most working time on outpatient primary care, 22% on outpatient secondary or

[2] Strictly speaking, the two distributions cannot be compared directly, because many questions—although trying to obtain similar information—were asked in different ways. Grouping of data can be different as well; therefore, some categories could only be loosely compared when combined together. See Table 1 below for more details. Summary of DH survey is available from: http://www.dh.gov.hk/textonly/english/statistics/statistics_hms/files/sumdr09.pdf.

[3] The sum is above 100% because multiple answers were allowed. DH's Manpower Survey asked the question differently (based on where the doctors had spent most of their working time, therefore no multiple answers were allowed).

tertiary care, 22% on inpatient or ambulatory care, and 9% responding doctors spent most working time on administrative or management work (Q3d).

- 77% obtained their basic medical degree in Hong Kong, 19% from overseas and 5% from Mainland China. This pattern again is similar to that reported by DH's survey (Q3h).
- When combining workplace and specialty characteristics of the responding doctors (for the purpose of the key subgroup analysis), we found 24% private GPs/FM specialists, 25% private non-FM specialists, 8% public GPs/FM specialists, 35% public non-FM specialists and 8% other doctors (such as trainees and retirees).

Table 1
Survey Respondents' Profile

	% Respondents	**DH 2009 Health Manpower Surve**	**Cohen's Effect Size**
Age (Q3g)			
30 or below	20.1%		
31 – 40	14.1%		
41- 50	27.8%		
51 – 60	18.9%		
60 or above	19.2 %		
Gender (Q3f)			
Male	72.5%	71.6%	0.01
Female	27.5%	28.4%	0.01
Work (Q3a)			
Full time	88.1%	86.4%	0.21
Part time	7.1%		
Not actively practicing	4.9%	13.6%*	0.09
Currently working in (Q3b) *(multiple options allowed)*			
Hospital Authority or Government departments	46.3%	47.2%	0.01
Private clinics (except those under private healthcare organizations)	37.7%	49.1%	0.06
Private clinics under private healthcare organizations	6.7%		
Private hospitals	9.8%		
Universities	4.6%	2.7%	0.02
Others	5.1%	1.0%	0.04
No. of participants choose more than 1 option	9.3%		
Best describe your current job (Q3e) (For those who are working in the private sector)			
Engaged in group practice as partner	11.3%		
Engaged in group practice as non-partner	13.3%		
As solo practitioner in private sector	69.3%		
As resident doctor in private hospital(s)	4.4%		
Others	1.6%		

	% Respondents	DH 2009 Health Manpower Surve	Cohen's Effect Size
Type of job (Q3c) *(multiple options allowed)*			
General practitioner	27.7%	33.2%**	0.00
Specialist in family medicine	5.8%		
Specialist in clinical area	54.7%	63.3%	0.04
Specialist in non-clinical area	4.9%		
Others	8.2%	3.5%	0.05
No. of participants choose more than 1 option	1.7%		
Spent most of their working time on (Q3d)			
Outpatient care of primary care nature	33.5%		
Outpatient care of secondary or tertiary nature	21.6%		
Inpatient care or ambulatory procedures	22.0%		
Administrative or management work	9.1%		
Others/retired	7.0%		
Evenly distributed among several categories	6.8%		
Basic medical degree obtained in (Q3h)			
Hong Kong	76.5%	75.0%	0.02
Overseas	18.9%	25.0%	0.02
Mainland China	4.6%		
Workplace-specialty (Q3b and Q3c)			
Private GPs/FM Specialists	23.6%		
Private Non-FM Specialists	24.7%		
Public GPs/FM Specialists	8.3%		
Public Non-FM Specialist	35.2%		
Others	8.2%		

Note: Cohen's *h* calculates the difference between pairs of proportions (Psychol Bull 1992; 112:155-9); the smaller the effect size, the more sample characteristics are similar to reference population.
* DH defined this as "economically inactive". All distributions presented exclude the "economically inactive".
** DH's grouping was based on where doctors spent most of working time, and allowed no multiple options.

3.2 Awareness about the HPS and Healthcare Reform

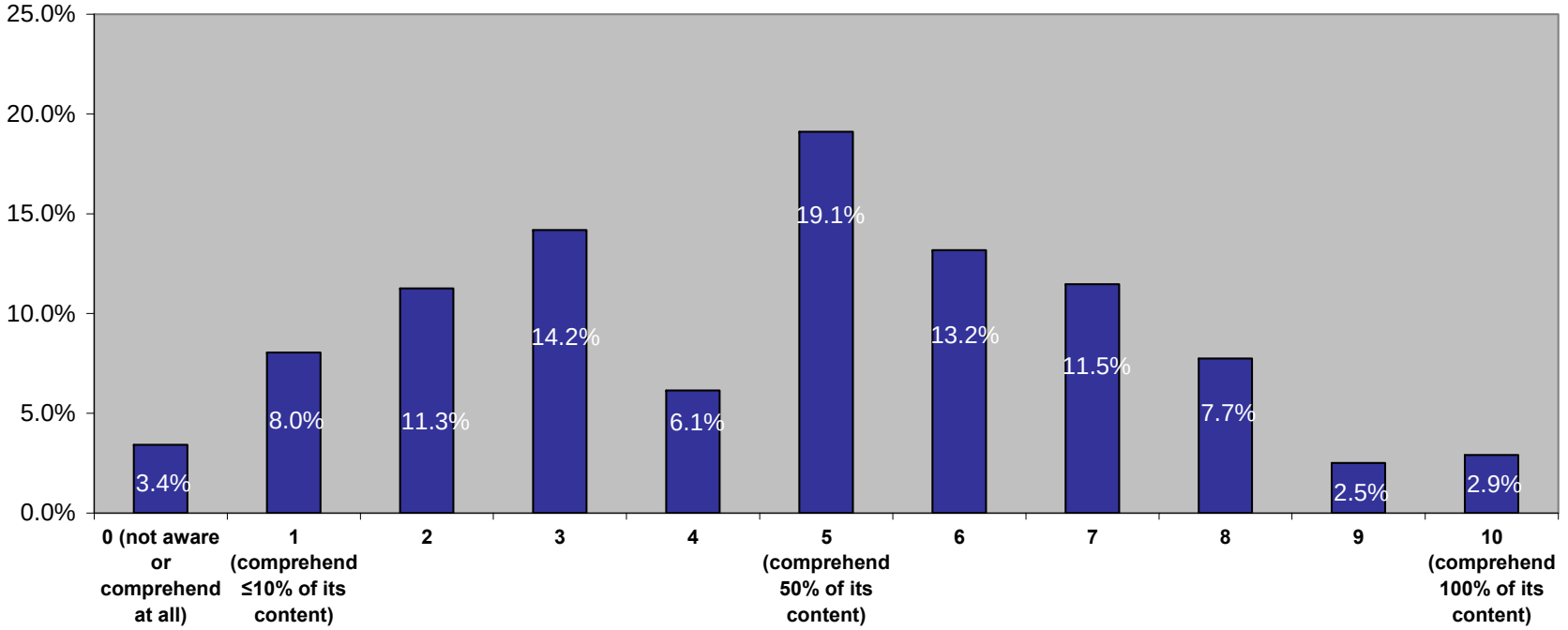
Knowledge of the HPS (Q1a)

Using a scale of 0-10 (0=not aware or comprehend at all; 1= comprehend $\leqq$10% of its content; 5=comprehend 50% of its content; 10=comprehend 100% of its content), 994 respondents rated their current knowledge of the HPS. Among them,

- 3% rated their current knowledge level as zero; on the other extreme, 3% gave a score of 10. Otherwise, 34% rated 1-3, 38% rated 4-6, and the remaining 22% responding doctors rated 7-9.
- The mean score is 4.7 (median 5.0), which suggests that on average, the responding doctors comprehended slightly less than 50% of the content of the HPS.
- Differences by workplace/specialty of the respondents are not statistically significant.

Figure 1

Q1a: How would you rate your current knowledge of the HPS, using a scale of 0-10?



Base: All respondents, excluding those who refused to answer (N=994)

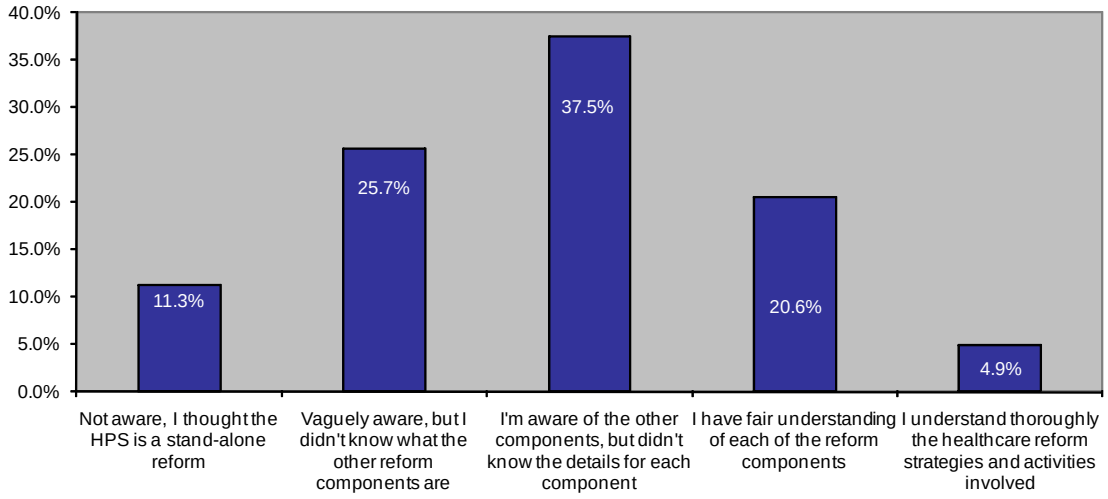
Awareness of the full package of reform (Q1b)

Of 1,054 doctors who answered this question, 11% thought the HPS is a stand-alone reform, and 63% were aware that the HPS is only part of a comprehensive healthcare reform package, but didn't know what the other reform components are or the details of each component. Nevertheless, a quarter of respondents reported having at least fair understanding of each reform component.

No statistically significant differences were found by workplace/specialty.

Figure 2

Q1b: Are you aware that the HPS is part of the healthcare reform that also includes enhancing primary care, promoting public-private partnership, developing electronic health records and strengthening public healthcare safety net?



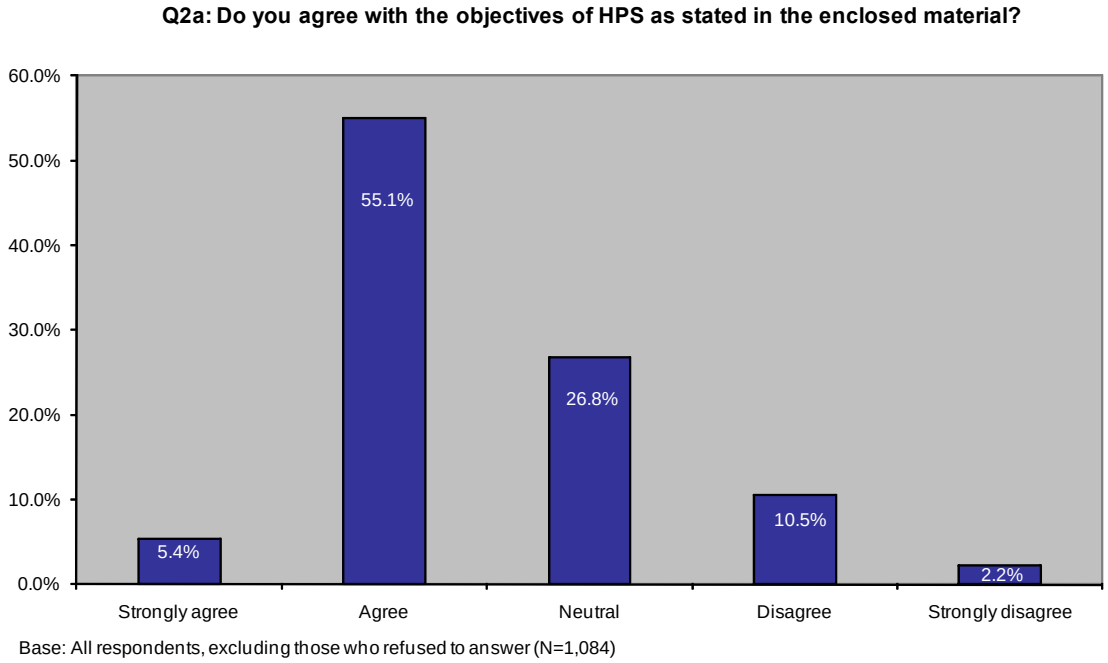
Base: All respondents, excluding those who refused to answer (N=1,054)

Agreement on HPS objectives (Q2a)

About 60% of responding doctors agreed or strongly agreed with the objectives of HPS as stated in the consultation document. On the other hand, 13% expressed disagreement.

Agreement rate among public doctors was significantly higher than that among private doctors. Particularly, more than 70% of public GPs/FM specialists agreed or strongly agreed with the objectives of HPS, whereas 53% of private GPs/FM specialists did so.

Figure 3



Base: All respondents, excluding those who refused to answer (N=1,084)

Table 2
Subgroup Analysis of Responses to Q2a by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
Private GPs/FM Specialists	52.8%	32.5%	14.6%	100.0%
Private Non-FM Specialists	54.8%	30.9%	14.3%	100.0%
Public GPs/FM Specialists	71.6%	21.6%	6.8%	100.0%
Public Non-FM Specialist	64.1%	22.4%	13.5%	100.0%
Others	69.0%	23.8%	7.1%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,047)

3.3 Views on Health Insurance, the HPS Design and Supporting Measures

3.3.1 Health Insurance Benefit Coverage

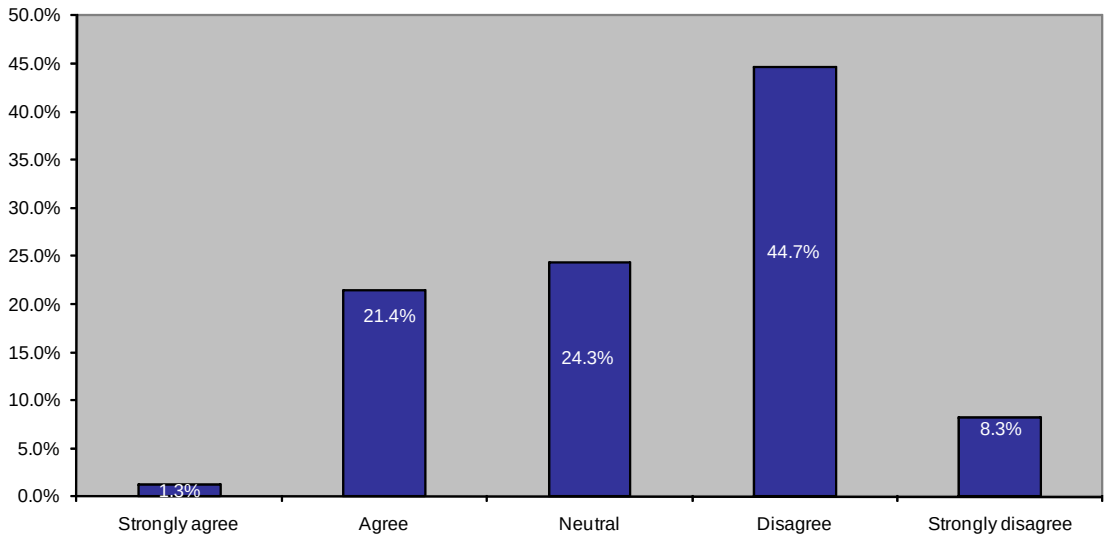
<u>Views on the performance of current health insurance market (Q2b and Q2c)</u>

Respondents expressed concerns over the performance of current health insurance market: slightly over half of the responding doctors did not think that the health insurance in the current market offers enough coverage for common treatments in private hospitals; an even higher percentage (61%) of respondents considered abuse of health insurance (e.g. unnecessary services, charge according to benefit limit) non-negligible.

Compared with other types of doctors, more public non-FM specialists expressed negative views on the performance of the current health insurance market. Whether working in the public or private sector was less important among GPs/FM specialists, when compared to public-private differences within non-FM specialists.

Figure 4

Q2b: Do you agree that health insurance in the current market offer enough coverage for common treatments in private hospitals?



Base: All respondents, excluding those who refused to answer (N=1,087)

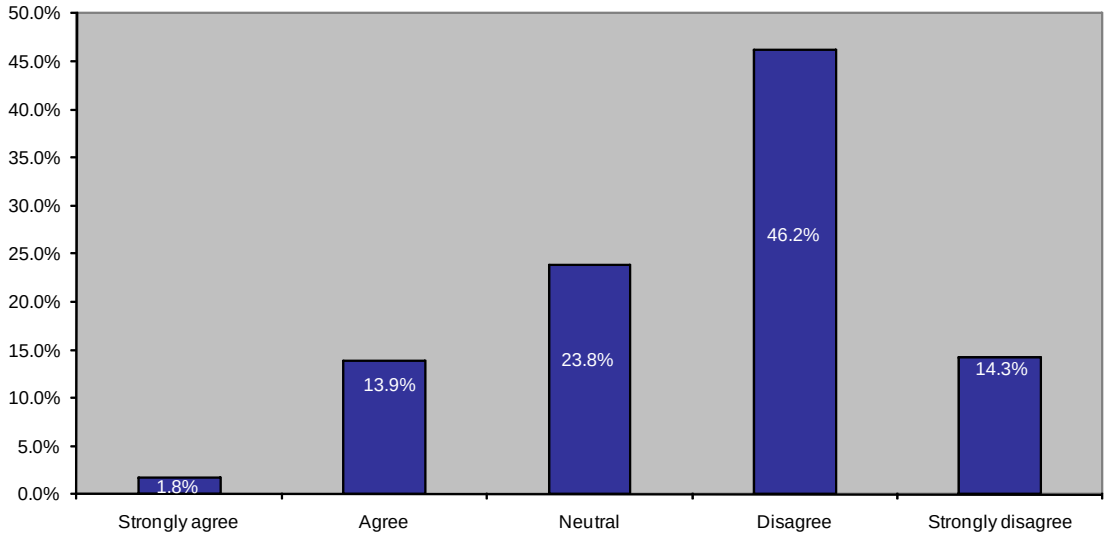
Table 3
Subgroup Analysis of Responses to Q2b by workplace/specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
Private GPs/FM Specialists	25.2%	24.4%	50.4%	100.0%
Private Non-FM Specialists	30.4%	19.6%	50.0%	100.0%
Public GPs/FM Specialists	19.3%	33.0%	47.7%	100.0%
Public Non-FM Specialist	18.1%	22.9%	59.0%	100.0%
Others	16.5%	31.8%	51.8%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,050)

Figure 5

Q2c: Do you agree that abuse of health insurance (e.g. unnecessary services, charge according to benefit limit) is negligible at present?



Base: All respondents, excluding those who refused to answer (N=1,084)

Table 4

Subgroup Analysis of Responses to Q2c by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
Private GPs/FM Specialists	17.5%	22.4%	60.2%	100.0%
Private Non-FM Specialists	21.0%	24.9%	54.1%	100.0%
Public GPs/FM Specialists	15.9%	25.0%	59.1%	100.0%
Public Non-FM Specialist	11.9%	20.8%	67.3%	100.0%
Others	9.3%	36.0%	54.7%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,047)

Priority in covering specific insurance benefits (Q2d)

As a private health insurance policy covers more benefits, its premium is expected to get higher. In order to gauge doctors' view on the priority-setting of insurance benefits coverage, we asked respondents to rank 6 insurance benefits in the order of importance (1=most important, 6=least important), 2% did not provide any indication, and another 6%, though ticked the benefits they considered important, did not give exact rank order as expected. Among those who ranked the 6 benefits, we looked at distribution across different ranks for each type of benefit and identified the rank with the highest percent of respondents:

- Large majority (72%) ranked hospital admissions as their most important benefits.
- 42% put ambulatory procedures (e.g. day surgeries) as the second most important benefit; though 12% considered this benefit as the most important one.
- 45% considered specialist outpatient services as their third most important benefits, 9% and 29% put it as #1 and #2, respectively.
- Less agreement was found for covering primary care: 35% put primary care in general (including general outpatient services and private GPs) only as their fourth most important benefits; however, 23% put it as #1 choice.
- Slightly over half (52%) of respondents put dental care as their fifth most important benefits, only before "other" unspecified services.

- Not surprisingly, when looking at different types of doctors, roughly one-third of GPs/FM specialists (33% public and 31% private) gave primary care the highest priority, much more likely than non-FM specialists (19% public and 15% private).
- The only other benefit where respondents showed statistically significant subgroup differences was ambulatory procedures: private doctors were more likely to rank it as #1 benefit to be covered by insurance than public doctors.

Table 5

Q2d: Please rank how important you think health insurance should cover the following (1 the most important to 6 the least important)

Coverage of Insurance Benefit		Rank (Row %)					
	1st	2nd	3rd	4th	5th	6th	Total
Hospital admissions (N=1022)	71.9%	8.9%	7.2%	4.3%	5.4%	2.3%	100%
Ambulatory procedures (e.g. day surgeries) (N=1023)	11.5%	42.1%	20.2%	17.0%	7.6%	1.5%	100%
Specialist outpatient services (N=1020)	9.0%	29.1%	45.2%	12.4%	3.5%	0.8%	100%
Primary care in general (including general outpatient services and private GPs) (N=1012)	23.1%	7.9%	11.6%	34.7%	18.6%	4.2%	100%
Dental care (N=1005)	5.2%	7.8%	10.2%	20.9%	51.9%	4.0%	100%
Other areas (N=278)	7.9%	2.5%	3.6%	6.5%	4.3%	75.2%	100%

Base: All respondents, excluding those who refused to answer the question or rank the benefits

Table 6

Subgroup Analysis of Responses to Q2d by Workplace/Specialty

	1st	2nd	3rd	4th	5th	6th	Total
Coverage of ambulatory procedures (N=990)							
Private GPs/FM Specialists	12.1%	37.1%	20.5%	19.6%	9.4%	1.3%	100.0%
Private Non-FM Specialists	13.4%	46.4%	20.9%	12.1%	6.3%	0.8%	100.0%
Public GPs/FM Specialists	5.9%	45.9%	11.8%	25.9%	8.2%	2.4%	100.0%
Public Non-FM Specialist	8.6%	45.0%	21.3%	16.9%	6.9%	1.4%	100.0%
Others	17.5%	28.8%	21.3%	17.5%	11.3%	3.8%	100.0%
Coverage of primary care in general (N=979)							
Private GPs/FM Specialists	31.3%	12.5%	13.8%	24.6%	12.1%	5.8%	100.0%
Private Non-FM Specialists	14.8%	5.9%	11.9%	42.4%	19.1%	5.9%	100.0%
Public GPs/FM Specialists	33.3%	8.3%	10.7%	32.1%	14.3%	1.2%	100.0%
Public Non-FM Specialist	19.4%	6.2%	9.0%	38.3%	24.2%	2.8%	100.0%
Others	28.8%	10.0%	15.0%	26.3%	15.0%	5.0%	100.0%

Base: All respondents, excluding those who refused to self identify or rank the benefits

3.3.2 Diagnosis-related groups (DRG)-Based Charging

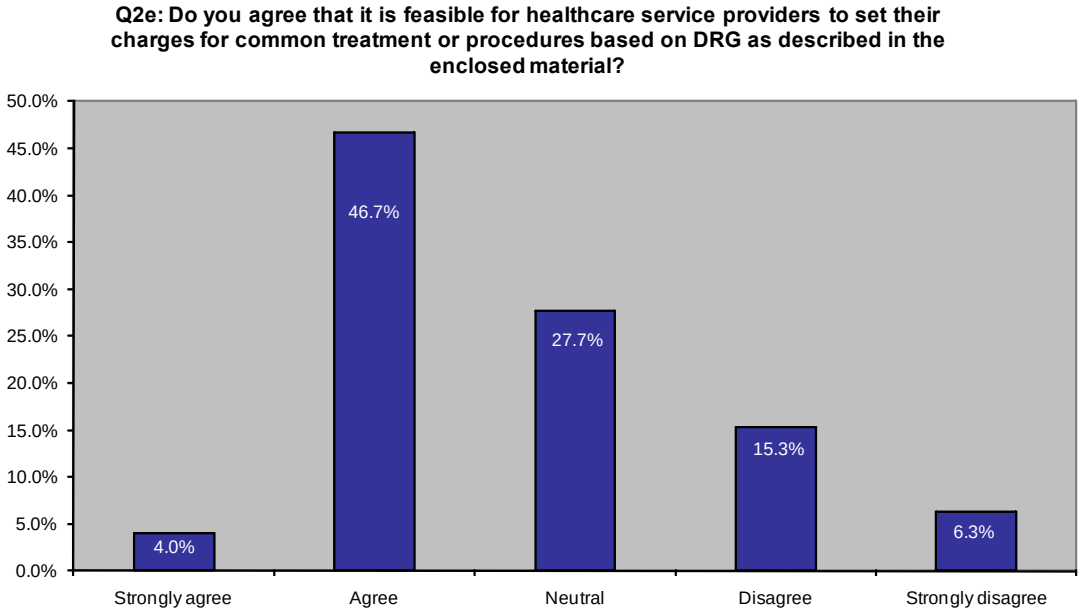
Feasibility of DRG-based charging (Q2e-g)

The introduction of a benefit structure based on DRGs to promote packaged charging among private healthcare providers is of direct relevance to the medical stakeholders. Therefore, we approached the question of its feasibility from three different perspectives.

First, a brief description of DRG-based charging was enclosed with the questionnaire. Based on their own understanding,

- Slightly over half of respondents (51%) agreed that it is feasible for healthcare service providers to set their charges for common treatments or procedures based on DRG as described in the enclosed material.
- More than a quarter (28%) of respondents reported neutral about its feasibility, possibly indicating less knowledge about the concept.
- Less than a quarter (22%) of respondents expressed disagreement with feasibility of DRG-based charging, including six percent who felt strongly about the disagreement.
- Small response variations were found among doctors with different workplace/specialty characteristics: 52% of public non-FM specialists agreed or strongly agreed that it's feasible to implement DRG-based charging, followed by private GPs/FM specialists (50%), private non-FM specialists (47%) and public GPs/FM specialists (46%).

Figure 6



Base: All respondents, excluding those who refused to answer (N=1,083)

Table 7

Subgroup Analysis of Responses to Q2e by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
Private GPs/FM Specialists	50.0%	29.3%	20.7%	100.0%
Private Non-FM Specialists	47.1%	21.4%	31.5%	100.0%
Public GPs/FM Specialists	45.5%	38.6%	15.9%	100.0%
Public Non-FM Specialist	52.0%	28.6%	19.4%	100.0%
Others	55.3%	29.4%	15.3%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,047)

Second, to further drill down the feasibility of DRG-based charging, we asked respondents to separately consider applying DRG to hospital charges alone, to doctor fees alone, or to all charges. Among the three options,

- A higher proportion of responding doctors agreed or strongly agreed that it is feasible to use DRG for setting hospital charges alone (except doctor fees) (option ii, 53%) than the other two options. Setting doctor fees alone based on DRG got the least support (iii, 29%), with less agreement than setting all charges based on DRG (i, 37%).
- Looking at proportions of respondents who disagreed or strongly disagreed with each option generates consistent result: hospital charges

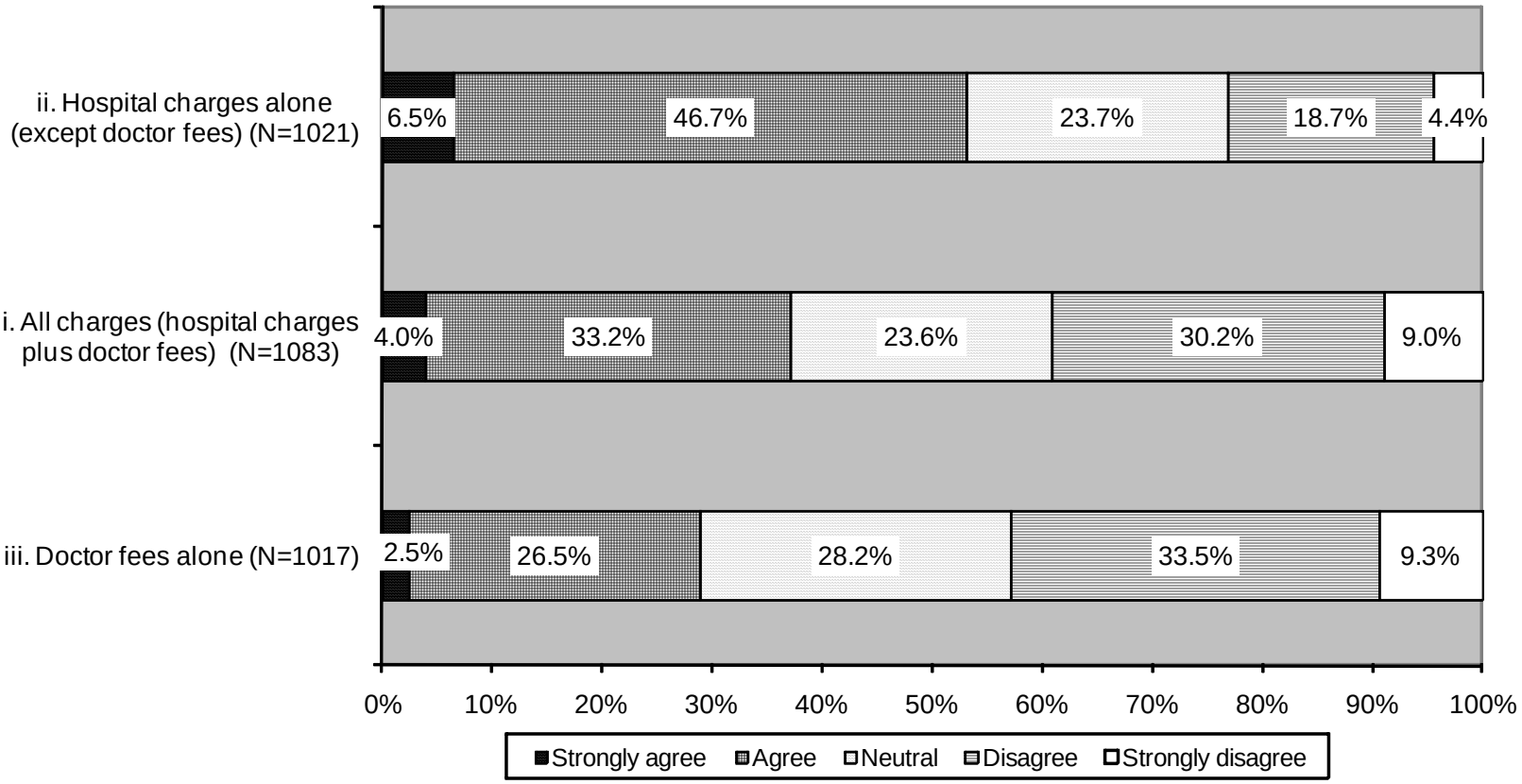
alone got the least disagreement (23%), followed by all charges (39%) and doctor fees alone (43%).

- Taken together, feasibility of DRG-based charging in hospital charges alone drew higher level of agreement than disagreement, but the reverse was true for doctor charges alone. Regarding feasibility of DRG-based charging for all charges, the difference between the level of agreement and the level of disagreement was relatively small.

- Among different types of doctors, public non-FM specialists always had the highest agreement rate to the feasibility of DRG-based charging, regardless of the implementation option. Taking the option of applying DRG to hospital charges alone, 57% public non-FM specialists agreed or strongly agreed with this option, higher than public GPs/FM specialists (55%), private non-FM specialists (51%) as well as private GPs/FM specialists (50%).
- Compared with the agreement rate data, larger subgroup differences apparently existed for disagreement rates. For example, 55% private non-FM specialists disagreed or strongly disagreed with applying DRG to all charges, whereas only 33% public GPs/FM specialists did so.

Figure 7

Q2f: Do you agree that it is feasible to set the following charges for common treatment or procedures based on DRG?



Base: All respondents, excluding those who refused to answer

Table 8

Subgroup Analysis of Responses to Q2f by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
i. All charges (hospital charges plus doctor fees) (N=1,047)				
Private GPs/FM Specialists	38.0%	23.3%	38.8%	100.0%
Private Non-FM Specialists	30.4%	15.2%	54.5%	100.0%
Public GPs/FM Specialists	35.2%	31.8%	33.0%	100.0%
Public Non-FM Specialist	40.2%	24.8%	35.0%	100.0%
Others	36.0%	34.9%	29.1%	100.0%
ii. Hospital charges alone (except doctor fees) (N=991)				
Private GPs/FM Specialists	49.8%	25.8%	24.4%	100.0%
Private Non-FM Specialists	51.4%	17.3%	31.3%	100.0%
Public GPs/FM Specialists	55.3%	25.9%	18.8%	100.0%
Public Non-FM Specialist	56.9%	23.7%	19.4%	100.0%
Others	50.0%	34.1%	15.9%	100.0%
iii. Doctor fees alone (N=987)				
Private GPs/FM Specialists	29.0%	30.8%	40.2%	100.0%
Private Non-FM Specialists	26.3%	16.6%	57.1%	100.0%
Public GPs/FM Specialists	29.4%	36.5%	34.1%	100.0%
Public Non-FM Specialist	31.2%	28.9%	39.8%	100.0%
Others	25.6%	43.9%	30.5%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

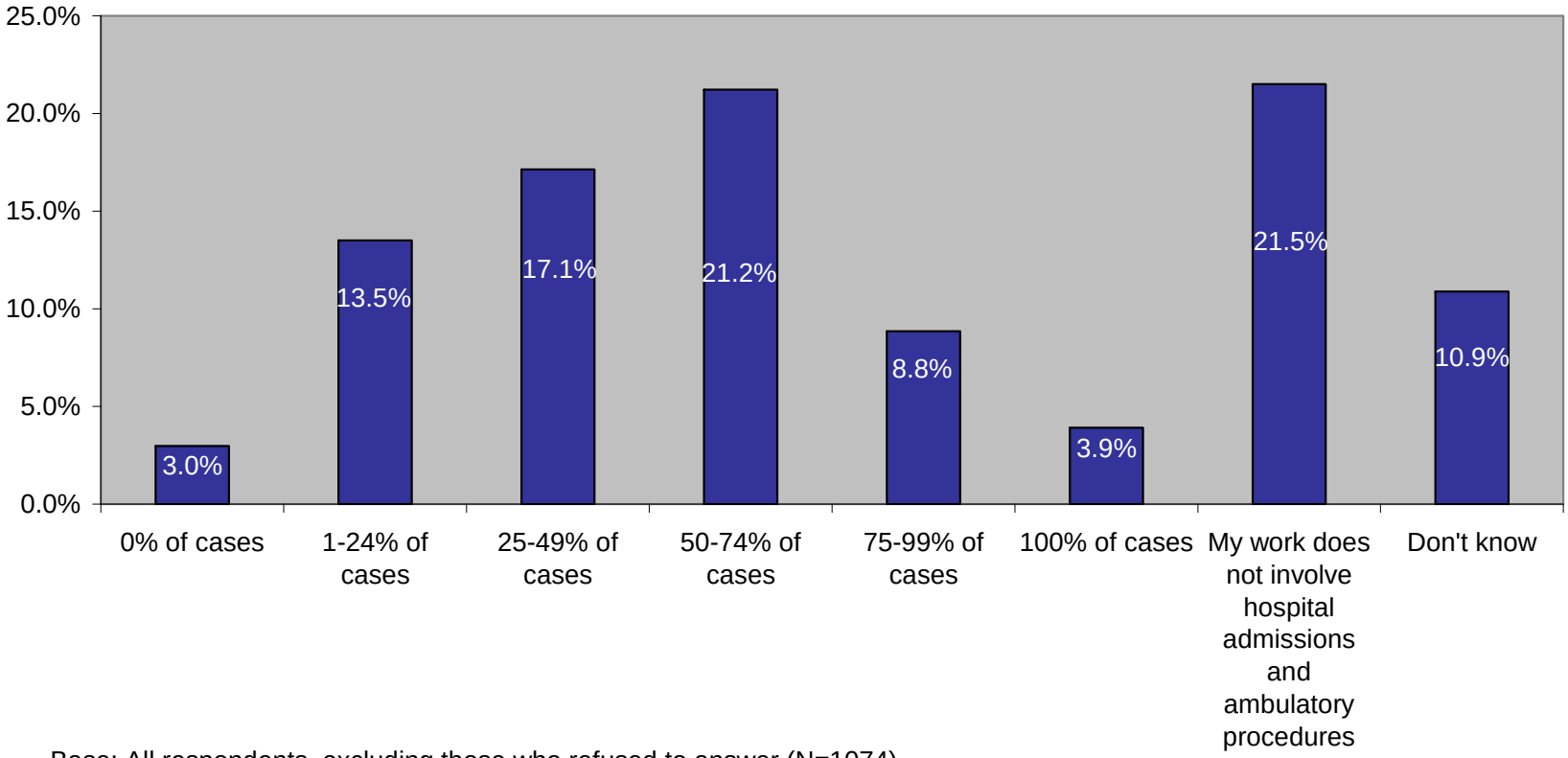
The third perspective was to gauge doctors' views on the feasibility of DRG-based charging by asking them to approach the question based on their own experience.

- Roughly one-third of respondents did not provide an opinion, either because their work does not involve hospital admissions or ambulatory procedures (22%) or they did not know how to answer the question (11%).
- Only 3% thought that none of cases of hospital admissions and ambulatory procedures processed by them would be feasible for DRG-based charging; on the other extreme, 4% responding doctors thought that DRG could be applied to 100% of their work cases.
- Most respondents considered DRG to be feasible for only some cases: 14%, 17%, 21%, 9% thought 1-24%, 25-49%, 50-74%, 75-99% of their own work cases would be feasible for DRG-based charging respectively.

- Looking at different types of doctors, less than 60% GPs/FM specialists (regardless of public or private) provided specific answers to this question, because they didn't think it's applicable to their work.
- Non-FM specialists considered DRG to be feasible for higher percent of their own work cases, compared with GPs/FM specialists. In particular, 45% public non-FM specialists thought it's feasible for half or more of their own work cases or more, whereas only 21% private GPs/FM specialists thought so.

Figure 8

Q2g: From your experience, what percentage of hospital admissions and ambulatory procedures processed by you would be feasible for DRG-based charging?



Base: All respondents, excluding those who refused to answer (N=1074)

Table 9

Subgroup Analysis of Responses to Q2g by Workplace/Specialty

	0-49% of cases	50-100% of cases	Not applicable to my work/Don't know	Total
Private GPs/FM Specialists	37.7%	20.9%	41.4%	100.0%
Private Non-FM Specialists	48.6%	37.3%	14.1%	100.0%
Public GPs/FM Specialists	31.0%	26.4%	42.5%	100.0%
Public Non-FM Specialist	26.2%	45.1%	28.6%	100.0%
Others	17.4%	26.7%	55.8%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,042)

Possible impacts of DRG-based charging (Q2h)

We provided eight possible impacts of implementation of DRG-based charging. Among them,

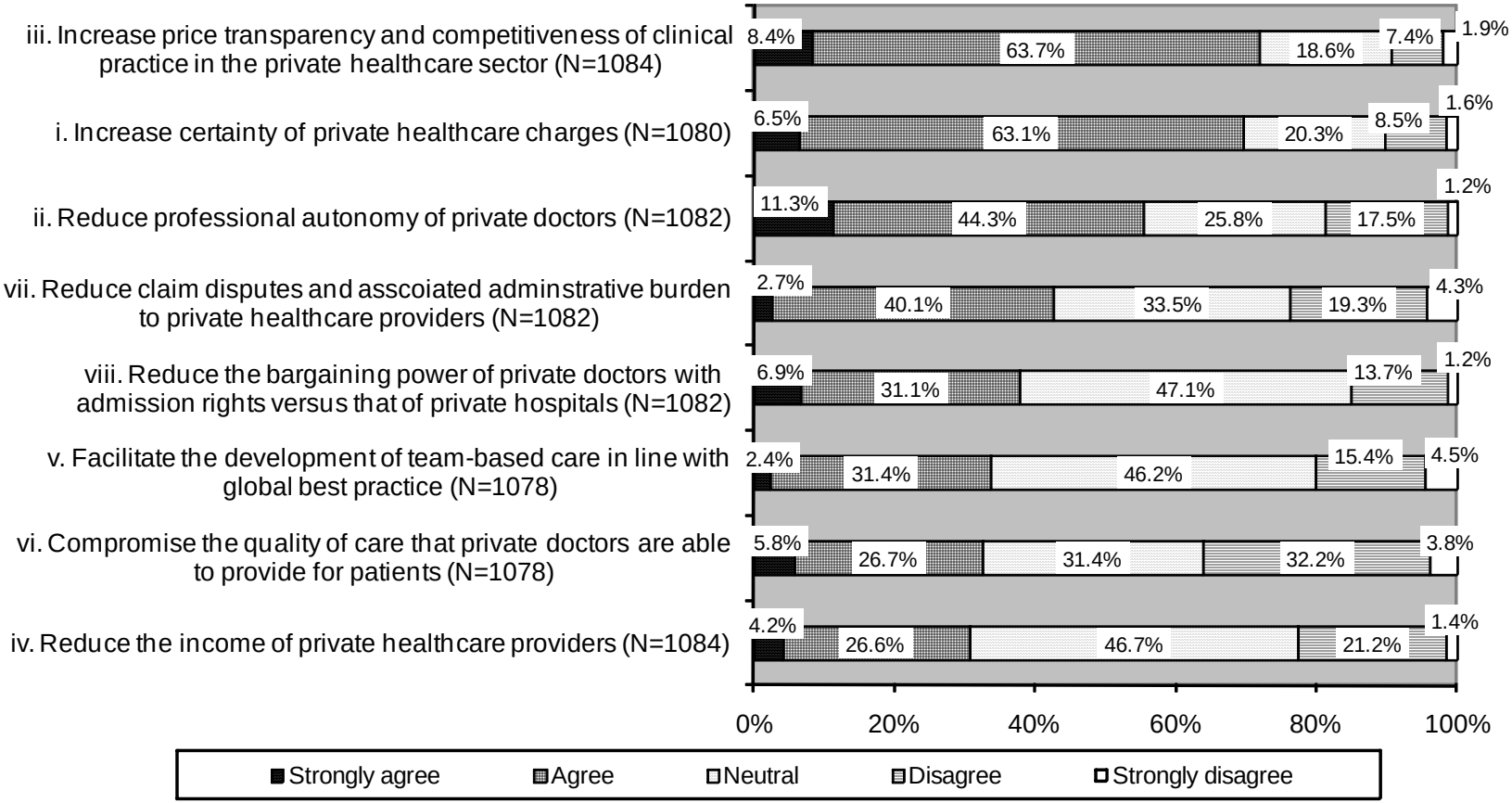
- The possible impact that gained most respondents' agreement was that DRG-based charging would "lead to increase in price transparency and competitiveness of clinical practice in the private healthcare sector" (option iii, 64% agree and 8% strongly agree), followed by "increase certainty of private healthcare charges" (option i, 63% agree and 7% strongly agree) and "reduce professional autonomy of private doctors" (option ii, 44% agree and 11% strongly agree).
- On the other hand, least agreement was with the statement that DRG-based charging would "lead to reduction in the income of private healthcare providers" (iv, 27% agree and 4% strongly agree), followed by "compromise the quality of care that private doctors are able to provide for patients" (vi, 27% agree and 6% strongly agree) and "facilitate the development of team-based care in line with global best practice" (v, 31% agree, 2% strongly agree).
- The rank order of the eight possible impacts by disagreement level was largely congruent with that by agreement level: again that DRG-based charging would lead to increase in price transparency and competitiveness of clinical practice in the private healthcare sector (iii) generated least disagreement. However, that DRG-based charging would lead to reduction in the income of private healthcare providers (iv) generated only the second most disagreement, while DRG-based charging would lead to compromise of quality of patient care (vi) generated the most disagreement.
- The proportions of respondents feeling neutral about the eight possible impacts were substantial, ranging from some 20% to almost 50%. Some

impacts received high proportions of “neutral”, for example, around 46-47% felt neutral (or perhaps uncertain) that DRG-based charging would reduce the bargaining power of private doctors (viii), reduce the income of private healthcare providers (iv), or facilitate the development of team-based care in line with global best practice (v).

- Significant subgroup differences were found in respondents’ opinion on each of the possible impacts. Details are shown in Table 10. Generally speaking, public doctors had higher agreement rates for positive impacts (e.g., i, iii, v), while private doctors had higher agreement rates for negative impacts (e.g., ii, iv, vi, viii).
- Some subgroup differences were quite large. For example, with respect to whether DRG-based charging would reduce income of private healthcare providers (iv), 42% private non-FM specialists agreed or strongly agreed, whereas only 19% public GPs/FM specialists did so.
- The smallest statistically significant subgroup differences were found with respect to whether DRG-based charging would reduce claim disputes and associated administrative burdens for private healthcare providers (vii)—only three percentage points separated private GPs/FM specialists (43% agreed or strongly agreed) and private non-FM specialists (40%).

Figure 9

2h: Do you agree that DRG-based charging would lead to the following?



Base: All respondents, excluding those who refused to answer

Table 10
Subgroup Analysis of Responses to Q2h by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
i. Increase certainty of private healthcare charges (N=1,046)				
Private GPs/FM Specialists	65.3%	24.1%	10.6%	100.0%
Private Non-FM Specialists	63.7%	18.8%	17.6%	100.0%
Public GPs/FM Specialists	71.6%	22.7%	5.7%	100.0%
Public Non-FM Specialist	73.9%	19.4%	6.7%	100.0%
Others	76.7%	17.4%	5.8%	100.0%
ii. Reduce professional autonomy of private doctors (N=1,048)				
Private GPs/FM Specialists	58.8%	28.2%	13.1%	100.0%
Private Non-FM Specialists	71.6%	15.6%	12.8%	100.0%
Public GPs/FM Specialists	44.3%	36.4%	19.3%	100.0%
Public Non-FM Specialist	46.5%	29.0%	24.5%	100.0%
Others	53.5%	23.3%	23.3%	100.0%
iii. Increase price transparency and competitiveness of clinical practice in the private healthcare sector (N=1,048)				
Private GPs/FM Specialists	70.3%	20.3%	9.3%	100.0%
Private Non-FM Specialists	63.4%	19.8%	16.7%	100.0%
Public GPs/FM Specialists	77.0%	17.2%	5.7%	100.0%
Public Non-FM Specialist	75.8%	17.2%	7.0%	100.0%
Others	79.1%	16.3%	4.7%	100.0%
iv. Reduce the income of private healthcare providers (N=1,049)				
Private GPs/FM Specialists	32.7%	47.3%	20.0%	100.0%
Private Non-FM Specialists	41.5%	38.0%	20.5%	100.0%
Public GPs/FM Specialists	19.3%	58.0%	22.7%	100.0%
Public Non-FM Specialist	25.0%	50.3%	24.7%	100.0%
Others	25.6%	45.3%	29.1%	100.0%
v. Facilitate the development of team-based care in line with global best practice (N=1,042)				
Private GPs/FM Specialists	28.6%	53.9%	17.6%	100.0%
Private Non-FM Specialists	28.3%	38.6%	33.1%	100.0%
Public GPs/FM Specialists	36.4%	52.3%	11.4%	100.0%
Public Non-FM Specialist	37.8%	45.7%	16.5%	100.0%
Others	34.1%	49.4%	16.5%	100.0%
vi. Compromise the quality of care that private doctors are able to provide for patients (N=1,045)				
Private GPs/FM Specialists	40.6%	30.3%	29.1%	100.0%
Private Non-FM Specialists	44.1%	23.4%	32.4%	100.0%
Public GPs/FM Specialists	29.9%	37.9%	32.2%	100.0%
Public Non-FM Specialist	21.2%	35.8%	43.0%	100.0%
Others	25.6%	33.7%	40.7%	100.0%
vii. Reduce claim disputes and associated administrative burden to private healthcare providers (N=1,047)				
Private GPs/FM Specialists	42.9%	35.1%	22.0%	100.0%
Private Non-FM Specialists	39.7%	28.0%	32.3%	100.0%
Public GPs/FM Specialists	41.4%	35.6%	23.0%	100.0%
Public Non-FM Specialist	41.7%	36.3%	22.0%	100.0%
Others	55.8%	26.7%	17.4%	100.0%

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
viii. Reduce the bargaining power of private doctors with admission rights versus that of private hospitals (N=1,045)				
Private GPs/FM Specialists	39.2%	49.8%	11.0%	100.0%
Private Non-FM Specialists	49.8%	32.5%	17.6%	100.0%
Public GPs/FM Specialists	32.2%	47.1%	20.7%	100.0%
Public Non-FM Specialist	31.7%	53.5%	14.8%	100.0%
Others	31.4%	54.7%	14.0%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

3.3.3 Regulatory Measures (Q2i)

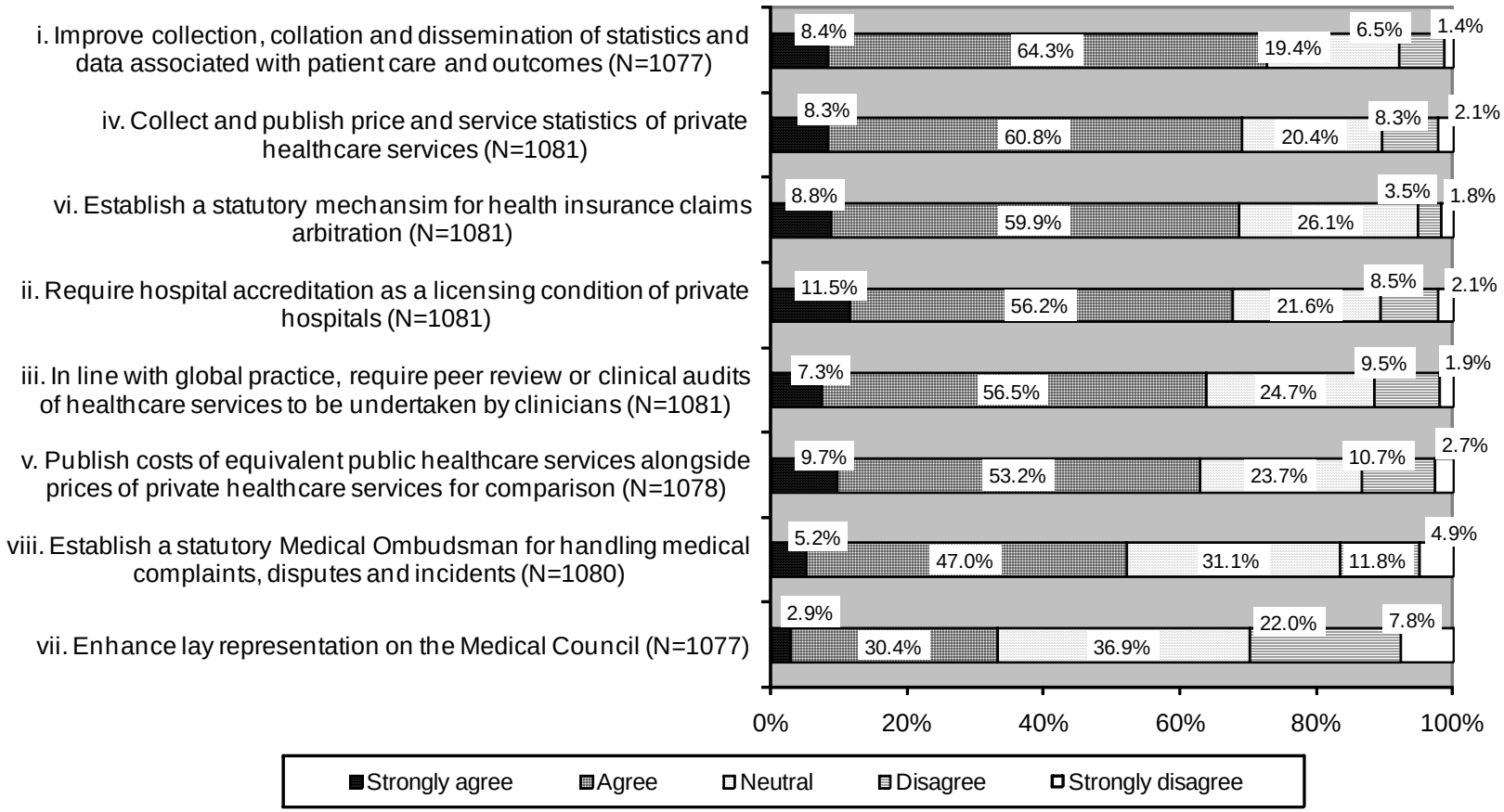
Doctors were asked about eight different regulatory measures that the Government would consider to use for support of HPS and promotion of healthcare system development. In general, we found high levels of agreement from responding doctors to most of these measures. In particular,

- More than 60% of responding doctors agreed with all but two measures. The two exceptions were: establishing a statutory Medical Ombudsman for handling medical complaints (measure viii, 52% agree or strongly agree) and enhancing lay representation on the Medical Council (vii, 33% agree or strongly agree); possibly due to lack of understanding of the concepts "Ombudsman" and "lay representation" (also signaled by high percent of "neutral" view expressed).
- The regulatory measure that gained most respondents' agreement on was improving collection, collation and dissemination of statistics and data associated with patient care and outcomes (i, 73% agree or strongly agree)
- If we look at the disagreement level, the rank order of the eight measures revealed a consistent picture. The only difference is that measure i (with highest agreement) only had the second lowest disagreement level. The measure had the least disagreement was establishing a statutory mechanism for health insurance claims arbitration (vi, 5% disagree or strongly disagree).

- Statistically significant subgroup differences were found in opinions on all regulatory measures, except two (measure ii, hospital accreditation and viii, statutory medical ombudsman).
- Again, in general, public doctors expressed stronger support for the Government to establish various regulatory measures than private doctors, especially public non-FM specialists. Taking the measure of requiring clinicians to undertake peer review or clinical audits (iii) as an example, 77% public non-FM specialists agreed or strongly agreed to this measure, much higher than the other three subgroups, including public GPs/FM specialists (64%), private non-FM specialists (56%) and private GPs/FM specialists (51%).

Figure 10

Q2i: Do you agree with the following regulatory measures which the Government may take to enhance transparency, increase competition and ensure quality of private healthcare services?



Base: All respondents, excluding those who refused to answer

Table 11
Subgroup Analysis of Responses to Q2i by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
i. Improve collection, collation and dissemination of statistics and data associated with patient care and outcomes (N=1,043)				
Private GPs/FM Specialists	61.9%	26.6%	11.5%	100.0%
Private Non-FM Specialists	61.6%	27.1%	11.4%	100.0%
Public GPs/FM Specialists	77.3%	17.0%	5.7%	100.0%
Public Non-FM Specialist	84.1%	11.1%	4.9%	100.0%
Others	82.6%	14.0%	3.5%	100.0%
iii. In line with global practice, require peer review or clinical audits of healthcare services to be undertaken by clinicians (N=1,046)				
Private GPs/FM Specialists	50.8%	32.0%	17.2%	100.0%
Private Non-FM Specialists	56.0%	28.0%	16.0%	100.0%
Public GPs/FM Specialists	64.4%	23.0%	12.6%	100.0%
Public Non-FM Specialist	77.4%	16.4%	6.2%	100.0%
Others	67.4%	26.7%	5.8%	100.0%
iv. Collect and publish price and service statistics of private healthcare services (N=1,046)				
Private GPs/FM Specialists	60.7%	24.8%	14.5%	100.0%
Private Non-FM Specialists	57.0%	26.0%	17.1%	100.0%
Public GPs/FM Specialists	73.9%	19.3%	6.8%	100.0%
Public Non-FM Specialist	78.8%	15.1%	6.2%	100.0%
Others	81.4%	14.0%	4.7%	100.0%
v. Publish costs of equivalent public healthcare services alongside prices of private healthcare services for comparison (N=1,044)				
Private GPs/FM Specialists	56.4%	29.6%	14.0%	100.0%
Private Non-FM Specialists	55.6%	25.7%	18.7%	100.0%
Public GPs/FM Specialists	66.7%	23.0%	10.3%	100.0%
Public Non-FM Specialist	68.3%	19.9%	11.8%	100.0%
Others	71.8%	20.0%	8.2%	100.0%
vi. Establish a statutory mechanism for health insurance claims arbitration (N=1,048)				
Private GPs/FM Specialists	61.9%	30.7%	7.4%	100.0%
Private Non-FM Specialists	63.6%	28.7%	7.8%	100.0%
Public GPs/FM Specialists	63.6%	33.0%	3.4%	100.0%
Public Non-FM Specialist	76.3%	20.2%	3.5%	100.0%
Others	73.3%	24.4%	2.3%	100.0%
vii. Enhance lay representation on the Medical Council (N=1,046)				
Private GPs/FM Specialists	32.0%	34.8%	33.2%	100.0%
Private Non-FM Specialists	25.3%	32.7%	42.0%	100.0%
Public GPs/FM Specialists	35.2%	42.0%	22.7%	100.0%
Public Non-FM Specialist	38.0%	37.5%	24.5%	100.0%
Others	31.4%	48.8%	19.8%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

3.3.4 Government Incentives (Q2j)

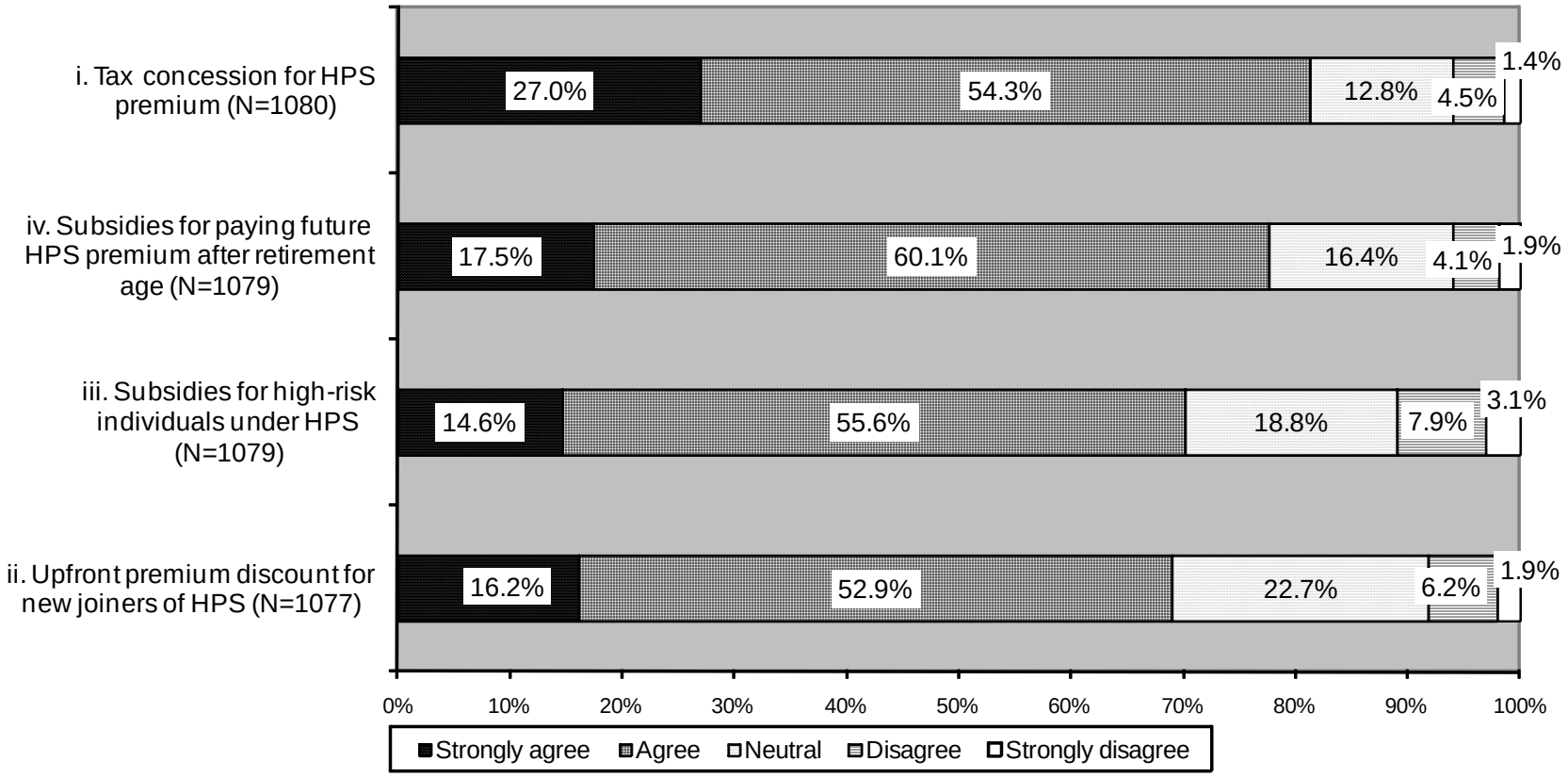
We also asked doctors about four types of financial incentives the Government would consider providing under HPS in order to encourage enrollment. Each of these incentives gained agreement from seventy or higher percent of responding doctors. In particular,

- Tax concession for HPS premium had the highest agreement level as well as the lowest disagreement level (incentive i); in fact, more than a quarter of respondents (27%) expressed strong agreement and another 54% agreed with this incentive; only 6% disagreed or strongly disagreed.
- Subsidies for paying future HPS premium after retirement age (iv) also had only 6% disagreement, but its agreement level was slightly lower than tax concession (18% strongly agree and 60% agree).
- Of the four measures, upfront premium discount for new joiners (ii) had the lowest agreement, and subsidies for high-risk individuals (iii) had the highest disagreement among responding doctors.

- Statistically significant subgroup differences were found in responses to only one of the four Government incentives, that is, to apply upfront premium discount for new joiners of HPS (ii): 76% public GPs/FM specialists agreed or strongly agreed to this incentive, followed by public non-FM specialists (73%), private non-FM specialists (68%) and private GPs/FM specialists (63%).

Figure11

Q2j: Do you agree with the following financial incentives which the Government may provide under HPS?



Base: All respondents, excluding those who refused to answer

Table 12
Subgroup Analysis of Responses to Q2j by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
ii. Upfront premium discount for new joiners of HPS (N=1,043)				
Private GPs/FM Specialists	63.4%	26.3%	10.3%	100.0%
Private Non-FM Specialists	68.0%	19.9%	12.1%	100.0%
Public GPs/FM Specialists	75.9%	21.8%	2.3%	100.0%
Public Non-FM Specialist	73.0%	20.5%	6.5%	100.0%
Others	64.0%	29.1%	7.0%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

3.3.5 Infrastructure and Manpower (Q2k)

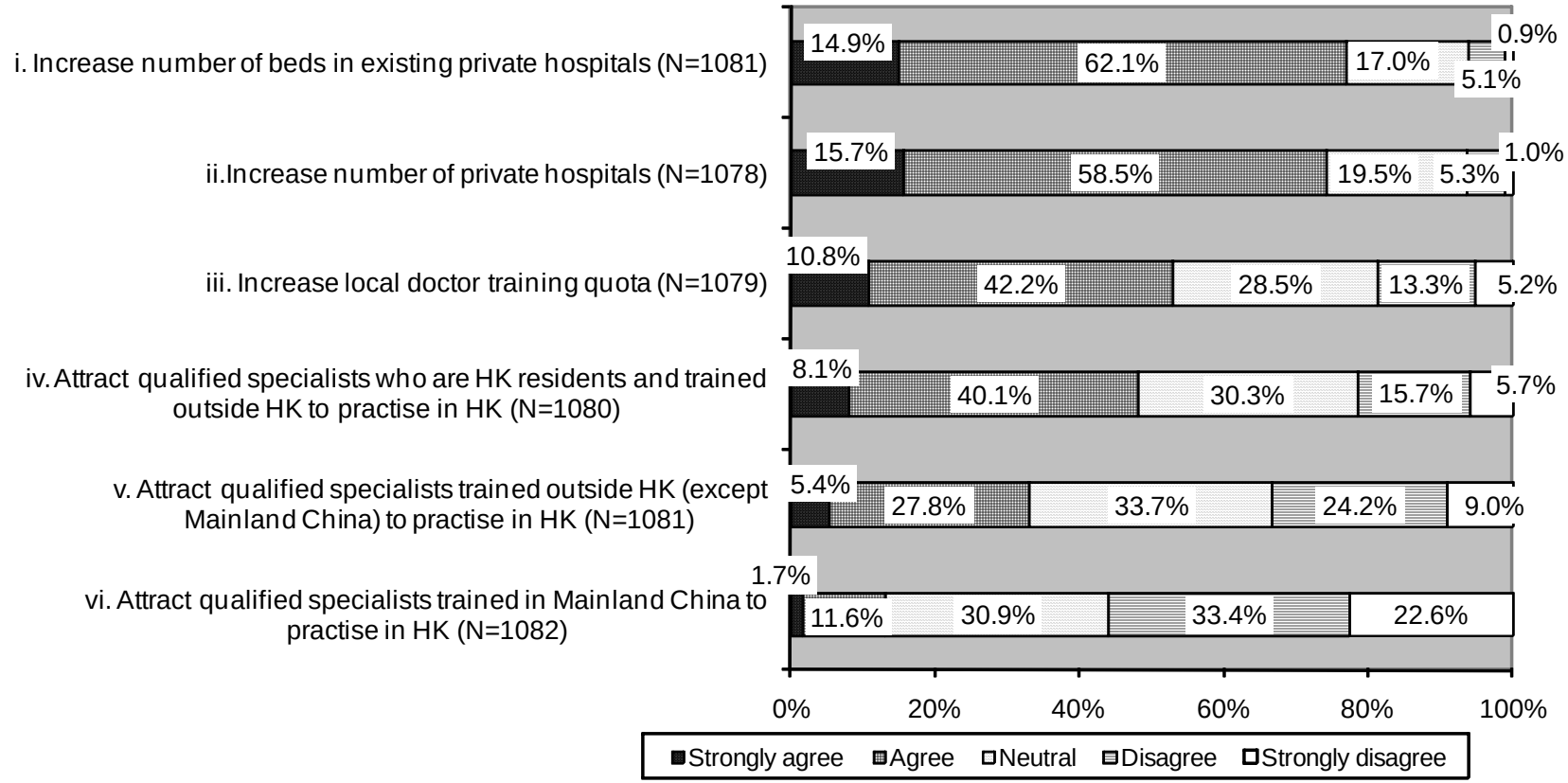
Anticipating higher demand for healthcare in the future, the Government would also consider implementing measures for healthcare infrastructure and manpower planning and to enhance supply of private healthcare services. Six such measures were provided to gauge doctors' views on this matter. We found varying degrees of agreement among responding doctors. More specifically,

- Responding doctors expressed strong opposition to attracting qualified specialists trained in Mainland China to practice in Hong Kong (measure vi): more than half (56%) disagreed or strongly disagreed to this measure, and only 13% agreed, the lowest among all manpower planning measures.
- Attracting qualified specialists trained outside HK (except Mainland China) got the next lowest agreement (v, 33%); by restricting to those who are HK residents (iv), the agreement level increased to 48%.
- More than half (53%) of responding doctors agreed with the measure to increase local doctor-training quota (iii).
- The largest proportion of responding doctors agreed that the Government may increase number of beds in existing private hospitals (i, 77%), followed by increase in number of private hospitals (ii, 74%). Both measures had low disagreement level too (6%).

- The most statistically significant subgroup differences were seen in doctors' view on increasing local doctor-training quota (iii): nearly 60% public doctors (GPs or specialists) agreed with this measure, while less than half of private doctors did so (47% GPs/specialists and 43% non-FM specialists).
- Interestingly, for most of other measures, it seems that responses from private GPs/FM specialists were closer to those from public non-FM specialists and very different from private non-FM specialists. Take increase in number of beds in existing private hospitals (i) as an example, 84% private non-FM specialists agreed or strongly agreed to this measure, higher than private GPs/FM specialists and public non-FM specialists (76% each) as well as public GPs/FM specialists (69%).

Figure12

Q2k: Do you agree with the following measures which the Government may take to enhance supply of private healthcare services?



Base: All respondents, excluding those who refused to answer

Table 13
Subgroup Analysis of Responses to Q2k by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
i. Increase number of beds in existing private hospitals (N=1,046)				
Private GPs/FM Specialists	75.5%	18.8%	5.7%	100.0%
Private Non-FM Specialists	84.4%	12.5%	3.1%	100.0%
Public GPs/FM Specialists	69.3%	18.2%	12.5%	100.0%
Public Non-FM Specialist	75.7%	17.8%	6.5%	100.0%
Others	77.9%	14.0%	8.1%	100.0%
ii. Increase number of private hospitals (N=1,044)				
Private GPs/FM Specialists	70.5%	23.4%	6.1%	100.0%
Private Non-FM Specialists	83.3%	13.6%	3.1%	100.0%
Public GPs/FM Specialists	62.5%	23.9%	13.6%	100.0%
Public Non-FM Specialist	74.3%	18.7%	7.0%	100.0%
Others	73.3%	19.8%	7.0%	100.0%
iii. Increase local doctor training quota (N=1,045)				
Private GPs/FM Specialists	47.1%	33.6%	19.3%	100.0%
Private Non-FM Specialists	43.0%	28.9%	28.1%	100.0%
Public GPs/FM Specialists	59.1%	23.9%	17.0%	100.0%
Public Non-FM Specialist	58.0%	28.3%	13.7%	100.0%
Others	67.4%	19.8%	12.8%	100.0%
iv. Attract qualified specialists who are HK residents and trained outside HK to practise in HK (N=1,045)				
Private GPs/FM Specialists	49.0%	31.4%	19.6%	100.0%
Private Non-FM Specialists	40.6%	30.5%	28.9%	100.0%
Public GPs/FM Specialists	44.3%	38.6%	17.0%	100.0%
Public Non-FM Specialist	50.4%	27.8%	21.8%	100.0%
Others	60.0%	28.2%	11.8%	100.0%
v. Attract qualified specialists trained outside HK (except Mainland China) to practise in HK (N=1,047)				
Private GPs/FM Specialists	32.9%	37.4%	29.7%	100.0%
Private Non-FM Specialists	25.8%	30.5%	43.8%	100.0%
Public GPs/FM Specialists	35.2%	38.6%	26.1%	100.0%
Public Non-FM Specialist	35.5%	30.1%	34.4%	100.0%
Others	43.5%	34.1%	22.4%	100.0%
vi. Attract qualified specialists trained in Mainland China to practise in HK (N=1,048)				
Private GPs/FM Specialists	15.9%	35.9%	48.2%	100.0%
Private Non-FM Specialists	8.6%	22.2%	69.3%	100.0%
Public GPs/FM Specialists	13.6%	36.4%	50.0%	100.0%
Public Non-FM Specialist	13.4%	29.0%	57.5%	100.0%
Others	15.1%	34.9%	50.0%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

3.4 Overall Impact of HPS (Q2l and Q2m)

We asked doctors for their opinions on specific possible impacts of the HPS as well as their overall impression on how HPS would influence the development of Hong Kong's healthcare system.

With regard to specific impacts, respondents seemed to favor more positive impacts:

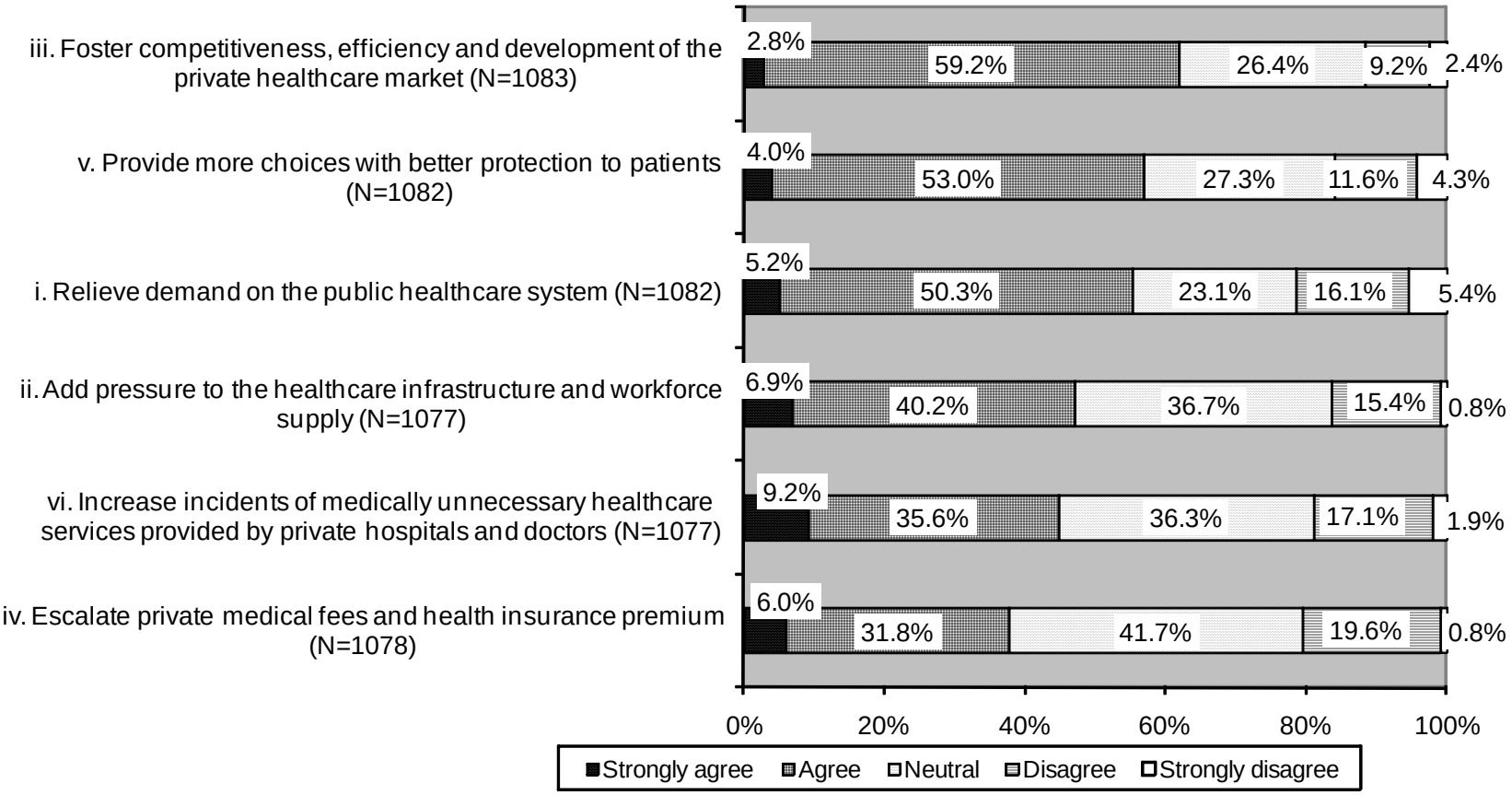
- The largest proportion of responding doctors agreed that the HPS will foster competitiveness, efficiency and development of the private healthcare market (measure iii, 62%), followed by that it will provide more choices with better protection to patients (v, 57%) and that it will relieve demand on the public healthcare system (i, 56%); all positive impacts.
- Lower levels of agreement were observed for the other three impacts which were less positive if not negative, with higher disagreement and higher neutral views: 47% agreed HPS would add pressure to the healthcare infrastructure and workforce supply (ii), 45% agreed that it would increase incidents of medically unnecessary healthcare services provided by private hospitals and doctors (vi) and only 38% agreed that it would escalate private medical fees and health insurance premium (iv).
- Interestingly, although more than half of respondents agreed that HPS will relieve demand on the public healthcare system (i), almost a quarter (22%) disagreed or strongly disagreed, making it the measure with the highest disagreement rate.

- Different types of doctors responded similarly to half of the possible impacts, that is, HPS would relieve demand on the public system (i), add pressure to workforce supply (ii) and increase medically unnecessary services (vi). No statistically significant analysis by subgroup is thus available for these. However, their views differed significantly for the other half.
- More specifically, a higher percent of public doctors agreed that HPS would foster competitiveness of the private market (iii) and provide more choices to patients (v) than private doctors. The agreement rate was the lowest among private non-FM specialists for both possible impacts.
- The split of opinions was somewhat different on that HPS would escalate private medical fees and health insurance premium (iv): GPs/FM specialists had higher agreement rate to this impact than non-FM

specialists, regardless of whether doctors were working in the public or private sector.

Figure 13

Q2l: Do you agree that the following will be the impacts of the HPS?



Base: All respondents, excluding those who refused to answer

Table 14
Subgroup Analysis of Responses to Q2l by Workplace/Specialty

	Agree/ Strongly agree	Neutral	Disagree/ Strongly disagree	Total
iii. Foster competitiveness, efficiency and development of the private healthcare market (N=1,049)				
Private GPs/FM Specialists	55.3%	29.3%	15.4%	100.0%
Private Non-FM Specialists	48.1%	34.1%	17.8%	100.0%
Public GPs/FM Specialists	69.0%	23.0%	8.0%	100.0%
Public Non-FM Specialist	70.4%	20.7%	8.9%	100.0%
Others	75.6%	22.1%	2.3%	100.0%
iv. Escalate private medical fees and health insurance premium (N=1,046)				
Private GPs/FM Specialists	44.0%	35.4%	20.6%	100.0%
Private Non-FM Specialists	33.7%	38.4%	27.9%	100.0%
Public GPs/FM Specialists	42.5%	41.4%	16.1%	100.0%
Public Non-FM Specialist	36.8%	46.2%	16.9%	100.0%
Others	34.9%	48.8%	16.3%	100.0%
v. Provide more choices with better protection to patients (N=1,048)				
Private GPs/FM Specialists	54.1%	27.6%	18.3%	100.0%
Private Non-FM Specialists	51.8%	25.3%	23.0%	100.0%
Public GPs/FM Specialists	60.9%	28.7%	10.3%	100.0%
Public Non-FM Specialist	58.9%	29.0%	12.1%	100.0%
Others	62.8%	24.4%	12.8%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question

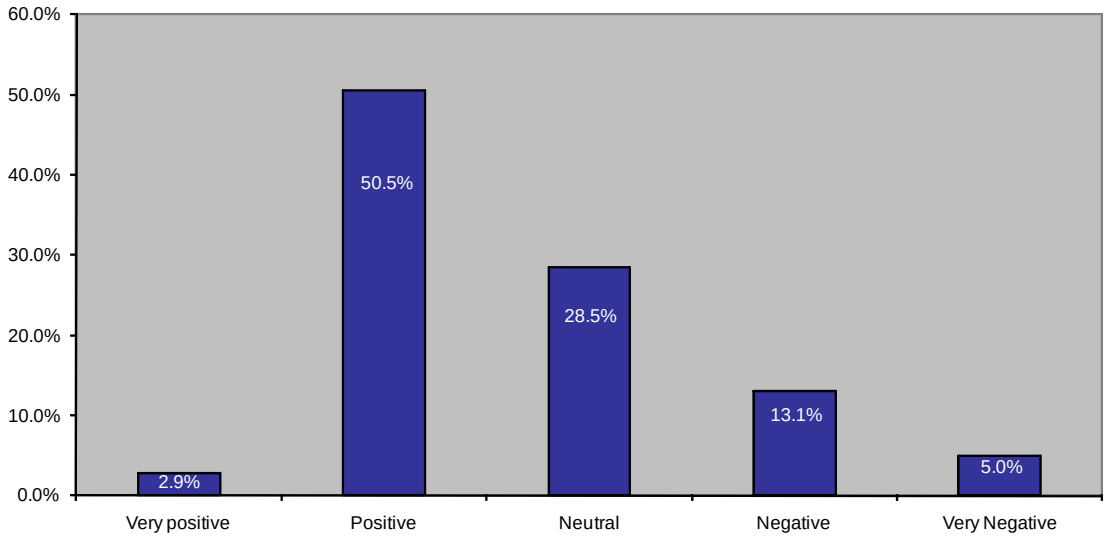
Echoing the previous responses to specific impacts, when asked about the overall long-term impact of HPS on the development of Hong Kong's healthcare system,

- Slightly over half of responding doctors felt positively (51%) or very positively (3%).
- However, 13% thought the impact would be negative, and 5% thought it to be very negative.
- The remaining 29% expressed neutral view, possibly reflecting either uncertainty about its impact or less knowledget about HPS to start with.

- Among different types of doctors, public GPs/FM specialists felt most positively about HPS's long-term impact (66% positive or very positive), followed by public non-FM specialists (58%) and private doctors (48% GPs/FM specialists and 47% non-FM specialists).

Figure 14

Q2m: Overall, what do you think about the long-term impact of HPS on the development of Hong Kong's healthcare system?



Base: All respondents, excluding those who refused to answer (N=1,077)

Table 15
Subgroup Analysis of Responses to Q2m by Workplace/Specialty

	Positive/ Very positive	Neutral	Negative/Very negative	Total
Private GPs/FM Specialists	48.0%	32.4%	19.7%	100.0%
Private Non-FM Specialists	47.1%	27.8%	25.1%	100.0%
Public GPs/FM Specialists	65.5%	23.0%	11.5%	100.0%
Public Non-FM Specialist	57.7%	27.0%	15.4%	100.0%
Others	54.7%	29.1%	16.3%	100.0%

Base: All respondents, excluding those who refused to self-identify or answer the question (N=1,043)

3.5 Summary of Other Subgroup Analyses

In addition to examining opinion differences between doctors defined by workplace (public vs. private) and specialty (GP/FM vs. non-FM specialists), further subgroup analyses of respondents' characteristics with their views on HPS were conducted. Each variable from part 3 of the questionnaire was cross-tabulated with variables from parts 1 and 2. Chi-square tests were conducted, with detailed results summarized in Table 16. Among eight characteristic variables we obtained data on, we found:

- Differences in views between doctors working in the public vs. private sector (Q3b) were statistically significant for nearly 80% of the questions.
- Respondents' age (Q3g) and gender (Q3f) were related to their views, and subgroup differences were statistically significant for 65% and 55% of the questions, respectively.
- Other practice-related information, for example, GP vs. specialists (Q3c), inpatient vs. outpatient (Q3d), and domestic vs. foreign medical degree (Q3h) also affected how doctors responded to the questionnaire. Subgroup differences within each of these variables were statistically significant for about 40% of the questions.
- Whether the doctor worked full-time, part-time or was not actively practicing (Q3a) was related to views on less than a third of the questions.
- For private doctors, whether they were engaged in group or solo practice or private hospitals (Q3e) was not related to any views expressed, except on HPS objectives and two regulatory measures.

In addition, for the following view-related questions, we found statistically significant differences by 5 or more respondents' characteristics:

- Awareness about HPS being part of a larger reform (Q1b)
- Abuse of current insurance coverage (Q2c)
- Rank of ambulatory procedures (Q2d_ii) or primary care as important benefit to cover (Q2d_iv)
- Feasibility of DRG-based charging in general (Q2e)
- Feasibility to setting all charges (Q2f_i) or doctor fees alone based on DRG (Q2f_iii)
- Percent of cases feasible for DRG based on own experience (Q2g)
- Impact of DRG-based charging on reducing professional autonomy (Q2h_ii) or reducing claim disputes (Q2h_vii)
- Regulatory measure to require peer review or clinical audits (Q2i_iii)
- Enhancing supply by attracting specialists trained outside HK (Q2k_iv-vi)

Table 16
Chi-square Test Results of Subgroup Analyses

Pearson Chi-Square	Respondents' Characteristics							
	3a Full vs. part time	3b Workplace	3c Specialty	3d Inpatient vs. out-patient	3e Group vs. solo	3f Gender	3g Age	3h Local vs. overseas degree
Awareness about HPS								
1a	0.037*	0.134	0.272	0.003*	0.613	0.368	0.000*	0.676
1b	0.066	0.041*	0.013*	0.000*	0.350	0.030*	0.004*	0.534
Health Insurance benefit coverage								
2a	0.241	0.003*	0.350	0.056	0.026*	0.059	0.014*	0.085
2b	0.205	0.006*	0.116	0.014*	0.328	0.466	0.012*	0.157
2c	0.001*	0.001*	0.022*	0.000*	0.372	0.928	0.676	0.015*
2d_i	0.666	0.022*	0.701	0.211	0.676	0.165	0.000*	0.155
2d_ii	0.039*	0.022*	0.004*	0.138	0.240	0.105	0.000*	0.005*
2d_iii	0.036*	0.022*	0.161	0.649	0.902	0.654	0.010*	0.096
2d_iv	0.007*	0.031*	0.000*	0.002*	0.736	0.931	0.000*	0.064
2d_v	0.000*	0.001*	0.525	0.013*	0.948	0.505	0.000*	0.091
2d_vi	0.125	0.602	0.873	0.677	0.661	0.549	0.023*	0.062
DRG-based charging								
2e	0.596	0.012*	0.047*	0.198	0.744	0.000*	0.000*	0.013*
2f_1	0.066	0.000*	0.017*	0.176	0.133	0.006*	0.000*	0.003*
2f_2	0.102	0.006*	0.090*	0.446	0.434	0.004*	0.001*	0.698
2f_3	0.619	0.006*	0.015*	0.008*	0.914	0.014*	0.000*	0.162
2g	0.000*	0.000*	0.000*	0.000*	0.431	0.021*	0.019*	0.215
2h1	0.351	0.004*	0.482	0.100	0.675	0.004*	0.099	0.007*
2h2	0.394	0.000*	0.000*	0.003*	0.291	0.003*	0.147	0.001*
2h3	0.359	0.000*	0.804	0.146	0.881	0.006*	0.184	0.307
2h4	0.037*	0.000*	0.042*	0.196	0.910	0.448	0.156	0.394
2h5	0.060	0.000*	0.106	0.179	0.747	0.012*	0.001*	0.132
2h6	0.132	0.000*	0.003*	0.000*	0.720	0.010*	0.043	0.115
2h7	0.029*	0.000*	0.020*	0.020*	0.731	0.000*	0.003*	0.045
2h8	0.548	0.000*	0.442	0.941	0.481	0.007*	0.011*	0.058
Regulatory Measures								
2i1	0.210	0.000*	0.001*	0.001*	0.536	0.086	0.143	0.839
2i2	0.471	0.011*	0.112	0.319	0.009*	0.569	0.000*	0.000*
2i3	0.651	0.000*	0.000*	0.000*	0.029*	0.058	0.229	0.000*
2i4	0.245	0.000*	0.065	0.018*	0.663	0.128	0.523	0.002*
2i5	0.181	0.001*	0.043*	0.071	0.217	0.228	0.270	0.037
2i6	0.237	0.000*	0.139	0.047	0.217	0.014*	0.002*	0.011*
2i7	0.784	0.000*	0.253	0.001	0.415	0.001*	0.262	0.001*
2i8	0.001*	0.168	0.091	0.492	0.717	0.000*	0.001*	0.000*

Pearson Chi-Square	Respondents' Characteristics							
	3a Full vs. part time	3b Workplace	3c Specialty	3d Inpatient vs. out-patient	3e Group vs. solo	3f Gender	3g Age	3h Local vs. overseas degree
Government Incentives								
2j1	0.239	0.187	0.166	0.604	0.928	0.067	0.290	0.093
2j2	0.333	0.119	0.204	0.994	0.845	0.036*	0.012*	0.010*
2j3	0.414	0.458	0.811	0.722	0.551	0.002*	0.002*	0.010*
2j4	0.811	0.462	0.820	0.871	0.837	0.002*	0.000*	0.002*
Infrastructure and manpower								
2k1	0.163	0.001*	0.265	0.514	0.612	0.014*	0.002*	0.088
2k2	0.025*	0.002*	0.094	0.744	0.830	0.003*	0.001*	0.105
2k3	0.002*	0.000*	0.320	0.018*	0.166	0.053	0.018*	0.565
2k4	0.108	0.000*	0.026*	0.000*	0.527	0.015*	0.001*	0.000*
2k5	0.090	0.004*	0.007*	0.000*	0.532	0.002*	0.002*	0.008*
2k6	0.008*	0.000*	0.010*	0.000*	0.941	0.292	0.005*	0.000*
Overall Impact								
2l1	0.417	0.770	0.935	0.969	0.211	0.001*	0.569	0.441
2l2	0.158	0.010*	0.655	0.183	0.131	0.019*	0.170	0.236
2l3	0.262	0.000*	0.021*	0.404	0.672	0.010*	0.055	0.292
2l4	0.003*	0.021*	0.602	0.018*	0.943	0.573	0.124	0.011*
2l5	0.041*	0.001*	0.907	0.571	0.789	0.052	0.001*	0.916
2l6	0.507	0.163	0.382	0.146	0.316	0.281	0.184	0.013*
2m	0.008*	0.020*	0.953	0.526	0.745	0.000*	0.001*	0.080

Note: Because Questions 3b (workplace) and 3c (specialty) allowed multiple answers, we created mutually exclusive subgroups under each question, before combining them into the 5 workplace/specialty categories. We assumed certain priority setting to do so. For question 3b (workplace), if the respondent chose one of the private options, regardless of what else he/she chose, he/she was categorized as working in the private sector; or else, if the respondent chose the Hospital Authority or universities option, he/she was categorized as working in the public sector; only those who chose "others" alone were categorized as "others". Similarly, for question 3c (specialty), we categorized respondents who chose specialist-clinical or specialist-nonclinical as "non-FM specialist", those who chose specialist-family medicine and general practitioner as "GP/FM Specialist"; and the rest as "others".

Appendix I

Questionnaire

Salient Descriptions of the Health Protection Scheme (HPS)

Desired <u>objectives</u> of HPS:

- Provide more choices with better protection to those who are able and willing to pay for private health insurance and private healthcare services
- Relieve public queues by enabling more people to choose private services and focus public healthcare on target service areas and population groups
- Better enable people with health insurance to stay insured and make premium payment at older age and meet their healthcare needs through private services
- Enhance transparency, competition, value-for-money and consumer protection in private health insurance and private healthcare services

HPS is <u>voluntary</u> in the sense that:

- Individuals may choose to subscribe on a voluntary basis to HPS Plans. Health insurers offer insurance plans and healthcare providers provide services under HPS in a free market.

HPS is <u>government-regulated</u> in the sense that:

- Participating insurers are required to offer health insurance plans that meet or exceed the core requirements and specifications for a standard health insurance plan under the HPS.
- Participating insurers are also required to comply with scheme rules and requirements specified under the HPS. These include:
  - adopting standardized policy terms and definitions
  - accepting all applicants and covering pre-existing conditions
  - allowing full portability between insurers
  - participating in re-insurance or risk-equalization
  - providing information on health insurance claims and costs
  - standardizing procedure coding and claims handling
  - participating in arbitration mechanism for claims.

HPS is <u>incentivized</u> in the sense that:

- Government will consider drawing $50 billion from the fiscal reserve to provide incentives for: (a) protection for high-risk individuals; (b) premium discount for new subscribers; (c) savings by individuals for paying future premium at older age.

DRG-Based Charging

- One major feature proposed for the HPS is to reimburse medical fees based on packaged charging for common treatments or procedures categorised by “diagnosis-related groups” (DRG).
- DRG-based charging has been a common practice in many countries for many years. It is widely considered as an effective way to make medical charges more transparent and predictable.
- DRG-based mechanism provides a transparent platform for doctors and hospitals to price their healthcare services according to DRG. Each provider may set their own price for (the services to be provided for) each DRG. **DRG is <u>not</u> centralized price-setting or price-fixing.**
- Under DRG-based charging, providers charge according to the diagnostic/procedural codes for the treatments or procedures performed. In general, the charge for each DRG is determined by the relative weight of the procedure covered and the base unit cost specific to the provider.
- DRG-based charge varies by degree of complexity of the actual case, under the same diagnosis category. In the event of co-morbidity or complications, the charge is also subject to upward adjustments from the baseline amount.

Medical Stakeholders Survey on Health Protection Scheme

Please fill in the appropriate circle like this: ● Choose only ONE option unless specified otherwise

Part 1: Awareness about the Health Protection Scheme (HPS) and Healthcare Reform

a) How would you rate your current knowledge of the HPS, using a scale of 0-10?
(0 = not aware or comprehend at all; 1 = comprehend ≤10% of its content;
5 = comprehend 50% of its content; 10 = comprehend 100% of its content)

Not aware/comprehend ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Full knowledge

b) Are you aware that the HPS is part of the healthcare reform that also includes enhancing primary care, promoting public-private partnership, developing electronic health records and strengthening public healthcare safety net?

- ○ Not aware, I thought the HPS is a stand-alone reform
- ○ Vaguely aware, but I didn't know what the other reform components are
- ○ I'm aware of the other components, but didn't know the details for each component
- ○ I have fair understanding of each of the reform components
- ○ I understand thoroughly the healthcare reform strategies and activities involved

Part 2: Views on health insurance, the HPS design and supporting measures

Health Insurance Benefit Coverage

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
a)	Do you agree with the objectives of HPS as stated in the enclosed material?	○	○	○	○	○
b)	Do you agree that health insurance in the current market offer enough coverage for common treatments in private hospitals?	○	○	○	○	○
c)	Do you agree that abuse of health insurance (e.g. unnecessary services, charge according to benefit limit) is negligible at present?	○	○	○	○	○

d) Please rank how important you think health insurance should cover the following (**1** the most important to **6** the least important):

- ☐ Hospital admissions
- ☐ Ambulatory procedures (e.g. day surgeries)
- ☐ Specialist outpatient services
- ☐ Primary care in general (including general outpatient services and private GPs)
- ☐ Dental care
- ☐ Other areas, please specify:_____

Diagnosis-related groups (DRG)-Based Charging

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
e)	Do you agree that it is feasible for healthcare service providers to set their charges for common treatment or procedures based on DRG as described in the enclosed material?	○	○	○	○	○
f)	Do you agree that it is feasible to set the following charges for common treatment or procedures based on DRG?					
	i. All charges (hospital charges plus doctor fees)	○	○	○	○	○
	ii. Hospital charges alone (except doctor fees)	○	○	○	○	○
	iii. Doctor fees alone	○	○	○	○	○

Please give reasons below to elaborate your views if you wish (optional):

g) From your own experience, what percentage of hospital admissions and ambulatory procedures processed by you would be feasible for DRG-based charging?

- ○ 0% of cases
- ○ 1-24% of cases
- ○ 25-49% of cases
- ○ 50-74% of cases
- ○ 75-99% of cases
- ○ 100% of cases
- ○ My work does not involve hospital admissions and ambulatory procedures
- ○ Don't know

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
h) Do you agree that DRG-based charging would lead to the following?					
i. Increase certainty of private healthcare charges	○	○	○	○	○
ii. Reduce professional autonomy of private doctors	○	○	○	○	○
iii. Increase price transparency and competitiveness of clinical practice in the private healthcare sector	○	○	○	○	○
iv. Reduce the income of private healthcare providers	○	○	○	○	○
v. Facilitate the development of team-based care in line with global best practice	○	○	○	○	○
vi. Compromise the quality of care that private doctors are able to provide for patients	○	○	○	○	○
vii. Reduce claim disputes and associated administrative burden to private healthcare providers	○	○	○	○	○
viii. Reduce the bargaining power of private doctors with admission rights versus that of private hospitals	○	○	○	○	○

Please give reasons below to elaborate your views if you wish (optional):

_____

Regulatory Measures

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
i) Do you agree with the following regulatory measures which the Government may take to enhance transparency, increase competition and ensure quality of private healthcare services?					
i. Improve collection, collation and dissemination of statistics and data associated with patient care and outcomes	○	○	○	○	○
ii. Require hospital accreditation as a licensing condition of private hospitals	○	○	○	○	○
iii. In line with global practice, require peer review or clinical audits of healthcare services to be undertaken by clinicians	○	○	○	○	○
iv. Collect and publish price and service statistics of private healthcare services	○	○	○	○	○
v. Publish costs of equivalent public healthcare services alongside prices of private healthcare services for comparison	○	○	○	○	○
vi. Establish a statutory mechanism for health insurance claims arbitration	○	○	○	○	○
vii. Enhance lay representation on the Medical Council	○	○	○	○	○
viii. Establish a statutory Medical Ombudsman for handling medical complaints, disputes and incidents	○	○	○	○	○

Please give reasons below to elaborate your views if you wish (optional):

_____

Government Incentives

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
j)	Do you agree with the following financial incentives which the Government may provide under HPS?					
	i. Tax concession for HPS premium	O	O	O	O	O
	ii. Upfront premium discount for new joiners of HPS	O	O	O	O	O
	iii. Subsidies for high-risk individuals under HPS	O	O	O	O	O
	iv. Subsidies for paying future HPS premium after retirement age	O	O	O	O	O

Please give reasons below to elaborate your views if you wish (optional):

_____

Infrastructure and Manpower

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
k)	Do you agree with the following measures which the Government may take to enhance supply of private healthcare services?					
	i. Increase number of beds in existing private hospitals	O	O	O	O	O
	ii. Increase number of private hospitals	O	O	O	O	O
	iii. Increase local doctor training quota	O	O	O	O	O
	iv. Attract qualified specialists who are HK residents and trained outside HK to practise in HK	O	O	O	O	O
	v. Attract qualified specialists trained outside HK (except Mainland China) to practise in HK	O	O	O	O	O
	vi. Attract qualified specialists trained in Mainland China to practise in HK	O	O	O	O	O

Please give reasons below to elaborate your views if you wish (optional):

_____

Overall Impact

		Strongly agree	Agree	Neutral	Disagree	Strongly disagree
l)	Do you agree that the following will be the impacts of the HPS?					
	i. Relieve demand on the public healthcare system	O	O	O	O	O
	ii. Add pressure to the healthcare infrastructure and workforce supply	O	O	O	O	O
	iii. Foster competitiveness, efficiency and development of the private healthcare market	O	O	O	O	O
	iv. Escalate private medical fees and health insurance premium	O	O	O	O	O
	v. Provide more choices with better protection to patients	O	O	O	O	O
	vi. Increase incidents of medically unnecessary healthcare services provided by private hospitals and doctors	O	O	O	O	O

		Very positive	Positive	Neutral	Negative	Very negative
m)	Overall, what do you think about the long-term impact of HPS on the development of Hong Kong's healthcare system?	O	O	O	O	O

Please give reasons below to elaborate your views if you wish (optional):

Part 3: Demographic Details

a) Your work in medical field is currently:
- ○ Full time
- ○ Part time
- ○ Not actively practicing

b) You are currently working in: **(multiple answers are allowed)**
- ○ Hospital Authority or Government Departments (e.g. Department of Health)
- ○ Private clinics (except those under private healthcare organizations)
- ○ Private clinics under private healthcare organizations
- ○ Private hospitals
- ○ Universities
- ○ Others, please specify:_____

c) You are working as a:
- ○ General practitioner
- ○ Specialist in family medicine
- ○ Specialist in clinical area, please specify:_____
- ○ Specialist in non-clinical area, please specify:_____
- ○ Others, please specify:_____

d) What is the proportion of working time you spend on the various nature of work? (Please fill in **"0 %"** for services you are not involved in):
- i. Outpatient care of primary care nature ( )%
- ii. Outpatient care of secondary or tertiary nature ( )%
- iii. Inpatient care or ambulatory procedures ( )%
- iv. Administrative or management work ( )%
- v. Others, please specify nature and % of time spent: _____

e) **[Please answer this question if you are working in the private sector]** Which of the following best describes your current job?
- ○ Engaged in group practice as partner
- ○ Engaged in group practice as non-partner
- ○ As solo practitioner in private sector
- ○ As resident doctor in private hospital(s)
- ○ Others, please specify:_____

f) Your gender: ○ Male ○ Female

g) Your age:
○ 30 or below ○ 31-40 ○ 41-50 ○ 51-60 ○ 61 or above

h) Your basic medical degree is obtained in: ○ Hong Kong ○ Overseas ○ Mainland China

i) We are in the process of recruiting doctors to participate in more in-depth focus group discussions regarding the HPS. Are you willing to participate?
○ Yes ○ No

[If yes, you are welcomed to contact Ms. Fion YING (fionying@cuhk.edu.hk or Tel: 2252-8742) for arrangement or provide your contact information below:]

Name: _____ Telephone: _____ Email: _____

If you have any additional comments, please return them with your completed questionnaire in the enclosed envelope. NO STAMP is required.

Thank you very much!

Appendix II

Number of Responses, by Question

Question	Number of responses	% Missing out of N=1,100
1a	994	9.6%
1b	1,054	4.2%
2a	1,084	1.5%
2b	1,087	1.2%
2c	1,084	1.5%
2d_i	1,022	7.1%
2d_ii	1,023	7.0%
2d_iii	1,020	7.3%
2d_iv	1,012	8.0%
2d_v	1,005	8.6%
2d_vi	278	74.7%*
2e	1,083	1.5%
2f_i	1,083	1.5%
2f_ii	1,021	7.2%
2f_iii	1,017	7.5%
2g	1,074	2.4%
2h_i	1,080	1.8%
2h_ii	1,082	1.6%
2h_iii	1,084	1.5%
2h_iv	1,084	1.5%
2h_v	1,078	2.0%
2h_vi	1,078	2.0%
2h_vii	1,082	1.6%
2h_viii	1,080	1.8%
2i_i	1,077	2.1%
2i_ii	1,081	1.7%
2i_iii	1,081	1.7%
2i_iv	1,081	1.7%
2i_v	1,078	2.0%
2i_vi	1,081	1.7%
2i_vii	1,080	1.8%
2i_viii	1,080	1.8%
2j_i	1,080	1.8%
2j_ii	1,077	2.1%
2j_iii	1,079	1.9%
2j_iv	1,079	1.9%
2k_i	1,081	1.7%
2k_ii	1,078	2.0%
2k_iii	1,079	1.9%
2k_iv	1,080	1.8%
2k_v	1,081	1.7%
2k_vi	1,082	1.6%

Question	Number of responses	% Missing out of N=1,100
2l_i	1,082	1.6%
2l_ii	1,077	2.1%
2l_iii	1,083	1.5%
2l_iv	1,078	2.0%
2l_v	1,082	1.6%
2l_vi	1,077	2.1%
2m	1,077	2.1%
3a	1,089	1.0%
3b	1,081	1.7%
3c	1,083	1.5%
3d_i	1,073	2.5%
3d_ii	1,079	1.9%
3d_iii	1,079	1.9%
3d_iv	1,078	2.0%
3d_v	1,100	0.0%
3e	450	59.1%*
3f	1,091	0.8%
3g	1,091	0.8%
3h	1,027	6.6%

Note: * High percent of missing is due to the fact that not every doctor is requested to answer the corresponding questions. Question 2d_vi allows doctors to identify additional areas of insurance benefit, if any; and only doctors working in the private sector are requested to answer question 3e (among them, 15.7% did not answer the question).