Regulation of Private Healthcare Facilities

Consultation Response

16 March 2015

Regulation of Private Healthcare Facilities Consultation response document

2. Executive Summary

supports efforts to prepare Hong Kong's private healthcare providers towards seamless care for a rapidly ageing society

2.1 supports the underlying principles of the Regulation of Private Healthcare Facilities (PHF) consultation to foster the robust development of the private healthcare sector to support the growing healthcare demands of Hong Kong's ageing population in partnership with the public healthcare sector in a seamless manner.

2.2. We support the PHF proposals of updating regulatory regime to align with international best practices for the private healthcare sector, specifically focusing on hospitals and out-patient ambulatory facilities where high-risk medical procedures are carried out. On the other hand, we believe that the medical services provided by doctors practicing at their own private clinics are of similar nature to the medical services provided by doctors practicing within a medical group or under the management of incorporated bodies, with strict governance from registration bodies such as Medical Council. Therefore, for the benefit and interests of the general public, we propose the inclusion of all medical facilities in the private sector as the overarching principle of the PHF proposal. With the vast number of solo medical practices in the private sector, we suggest taking a staged approach in the implementation to include all private hospitals and out-patient ambulatory facilities with high–risk medical procedures in the first phase, followed by all other private medical facilities in the second phase.

2.3 We are supportive of voluntary enrolment onto the eHRSS for more seamless care transition between the public and private health care sectors, and we advocate fee transparency to empower consumer choice in selecting health care services.

2.4 We look forward to further consideration by the Food & Health Bureau in the scope of healthcare facilities to be put under the new regulatory regime, and welcome further collaboration with the Bureau for more in-depth discussion of this consultation document.

3. Comments on the proposed three classes of private healthcare facilities

New regulatory regime covering three classes of private healthcare facilities -Private hospitals:

3.1 Private healthcare is providing over 70% of outpatient services while public healthcare sector is supporting 80% of inpatient admissions in Hong Kong. We are supportive of the proposal to introduce the new regulatory regime for private hospitals which will enhance the transparency and accountability of the facilities, and can thereby contribute to a shift of more patients to the private sector and lead to a better balance between the public and private healthcare sector for patients seeking inpatient care.

-Facilities providing high-risk medical procedures in ambulatory setting

3.2 Providing medical procedures in ambulatory setting is a growing world-wide trend that is cost-effective and a preferred choice for doctors and patients for carefully selected medical conditions. While we are supportive of the proposal for introducing the new regulatory regime for facilities providing high-risk medical procedures in ambulatory setting, we look forward to further elaboration on defining the list of high-risk medical procedures.

-Facilities providing medical services under the management of incorporated bodies

3.3 Clinical autonomy is the most fundamental and foremost principle for all doctors working . It is of dispute that operational risks for facilities providing medical services under the management of incorporated bodies will be any different from doctors-owned and operated practices.

3.4 Similar to Hospital Authority, infrastructure in the head office, such as the 24/7 Medical Call Centre, and different supporting departments such as human resources, information technology, are set up to support the operation of our medical centres and service delivery by our doctors.

3.5 Private healthcare sector is responsible for taking care of over 70% of outpatient services. All doctors practicing in these setting are currently regulated by their professional registration bodies, and many doctors work at more than one single location, apportioning their time between different medical centres that may be privately owned by a number of doctors, solely owned, or under the management of incorporated bodies. Henceforth it may not be practical to include only facilities providing medical services under the management of incorporated bodies to be put under the new regulatory regime proposed but should instead include all private medical facilities through a staged approach.

4. Comments on the proposed PHF Regulatory Aspects

Group A – Corporate Governance

4.1 We recognize the benefits of corporate governance and fully support the proposed appointment of person-in-charge, the establishment of medical advisory committee, and the establishment of a complaints management system. has indeed been a pioneer in the private healthcare industry to establish our own Clinical Governance Structure supported by committees including Medical Standards Compliance Committee, Drug and Technology Committee, Specialists Practice Committee, and Dental Standards Compliance Committee to ensure the delivery of medical services that are of high quality and standards. The Clinical Governance framework and structure of are included in the Appendix for reference. Similarly, we have established a Complaints Management System with grading and clearly defined management protocols across all frontline and back office touchpoints.

4.2 With regards to the information system connectable with eHRSS, we believe that connectivity of medical records through electronic system across all providers in the public and private healthcare sectors is essential for delivering seamless care to the general public and reduces redundant investigations and treatment. It will be desirable to incentivize private sector practitioners to go onto the eHRSS through some funding support or tax incentive to expedite this initiative.

4.3. We believe performance assessment through accreditation can help private healthcare facilities promote corporate governance and encourage continuous

quality improvement. Consideration has to be made on the planning and resources requirement and we support the staged approach for the accreditation implementation for private hospitals first then followed by non-hospital PHFs.

Group B. Standard of Facilities

Premises Management and Physical Conditions

4.4. With regards to the requirements under Premises Management and Physical Conditions, we have concerns as many of the non-hospital PHFs are located in commercial buildings through rental arrangement, so there needs to be further consideration of related building and construction ordinances directed towards property developers, property management companies, and responsibilities of landlords for compliance to the mandatory requirement such as regular maintenance of the building to ensure safe and secure access, special ventilation requirements for chemotherapy centres, and back-up power arrangement. At the moment, buildings and facilities maintenance are by invitation and not mandated across the board and there is not yet a standard protocol to submit maintenance records to appointed authorized bodies, henceforth it will be beyond the control of the PHFs to comply with such requirements.

Infection Control

4.5. We support the proposal of the mandatory requirements on infection control for the safety and wellbeing of the public using the PHF.

Group C. Clinical Quality

Service Delivery and Care Process

4.6. We have concerns on the ongoing shortage of qualified manpower available in the private healthcare sector. Henceforth, we propose that prior to the implementation of mandatory requirements on specified number of qualified staff on duty, a survey on the current manpower status in the non-hospital PHFs may be necessary to understand the current manpower supply and demand of

qualified staff in the private healthcare sector to ensure compliance feasibility.

Resuscitation and Contingency

4.7. We support the proposal.

Standards Specific to Procedures Performed

4.8 For non-hospital PHFs, the facilities may be under the jurisdiction of landlord / property management and relevant stakeholders and building and construction ordinances should be reviewed prior to the implementation of certain standards.

Credentialing of Visiting Doctors

4.9 We support the proposal.

Establishment of Clinical Audit System

4.10. We support the proposal.

Sentinel Events Management considered in future

4.10 We support the proposal.

Group D. Price Transparency

4.11 There has been a general lack of fee transparency in the private healthcare sector, especially with inpatient services at private hospitals, whereby there are huge variations between hospitals and hardly any reference figures for consumers to plan their budget. Adopting price transparency will enable more informed choices for consumers and more confidence in utilizing the private healthcare sector within their means.

Provision of Fee Schedule

4.12 A common list of chargeable items for a PHF can go beyond thousands of items, and we are concerned that of the significant resources that the PHFs have to

put in to publish and update the list on a regular basis. We propose the publication of a selected list of common items as a pragmatic approach to allow relevant information to be available for the general public. For example, for in-patient care, the list should include the package rate of the top 50 most commonly done procedures for general ward, second class and first class respectively, and common practice overseas may link the surgery list with average length of stay for the public's easy reference.

4.13 For out-patient care, we propose that the list should include doctor's consultation rate, top 100 most commonly prescribed medication, top 50 laboratory items and investigations for reference, and top 10 commonly done procedures in the out-patient setting. Certain fee schedules, such as contract rates signed between the private healthcare organization and corporate clients, may need to be exempted from being listed publicly due to commercial confidentiality.

Provision of Quotation

4.14 We support this proposal.

Recognized Service Packages

4.15 We support this proposal.

Disclosure of Statistics

4.16 We support this proposal.

Group E. Sanctions

4.17 We support this proposal.