I am enclosing an article published in December 2004 issue of Bottomline, (Chartered Institute of Management Accountants monthly magazine) on the subject of healthcare costing and its implication on healthcare reform. I am no longer in the forefront of promoting ABC (Activitity Based Costing) in Hong Kong. However, the DRG/HRG mythodology used around the world is still the foundation of resource allocation in healthcare reform.

I have also summaried some comments I made to you at your presentation at Professional Commons:

1. The HKSARG should not look at financial inputs exclusively when doing financial projection models. Some attention to outputs -- better resources management, incentives for service providers to improve their efficiency and facilitation of some degree of competition could reverse the government input projection significantly.

2. As I understand it, the world is following the so called "Dutch Heathcare Reform Model". http://www.minvws.nl/en/themes/health-insurance-system/the-new-health-care-system-in-the-Netherlands-video/
Both UK and Australia are late adoptors. Hong Kong should at least consider the Dutch Healthcare System carefully before deciding on what to do next.

3. Personally, I believe "Social Insurance" (mandatory insurance at a minimum level for everyone in the community -- government to pay for premium for those who could not afford to pay), personal savings (i.e. not mandatory savings locked in a government account) topped up with optional private insurance is the answer. I am not against setting up a government owned insurance company to soak up all the "bad insurance risks" (e.g. old folks, disabled, those with long-term illnesses and others who cannot afford to pay but are likely to have high healthcare needs).

4. I believe the HKSARG should set a direction and try to overcome the skeptics in the community. It should not recommend a bit of everything since the overhead cost involved in a bit of everything is extremely high.

5. With regard to your comment that it is difficult to implement HRG/DRG (Activity Based Costing based methodology) in hospital environment, I think policy decision makers such as yourself need to distinguish how much of the objection is real practical difficulties and how much of it is resistance to change and accountability. As a former Activity Based Costing practitioner, I can tell that the H&FB is more likely facing "resistisance to change" than "practical aspects" of HRG/DRG implementation. The new Australian CE of HA is still the key to change. At a practical level, there is abundant supply of HRG/DRG knowhow from Europe. I know that a standard list of 2,000 HRG/DRGs (i.e. a list of 2,000 high level medical procedures) exists. As Hong Kong uses English as a business language, there is no barrier to import HRG/DRG based resource management systems.

UNQUOTE

Regards,
Alan

Alan Lung
Asia Pacific Intellectual Capital Centre

CIMA

The Bottomline

Hong Kong Division Sept-Dec 2004 Issue

Gazing into a crystal ball at

Healthcare Costing and Cost Management in Hong Kong

Dr Joseph Yau, Council Member of CIMA Hong Kong Division and Assistant Professor, School of Business & Administration, The Open University of Hong Kong

Alan Lung, General Committee Member of Management Consultancy Association of Hong Kong and General Manager, ABCM Consulting (China) Ltd

Dr York Chow, the newly appointed health secretary for Hong Kong announced that an advisory committee will be set up in December 2004 to examine the healthcare financing options for Hong Kong.[1] Dr Chow took on a difficult but very important subject. Hong Kong may not be able to fund the public health service entirely from the public purse. The fund is given to the Hospital Authority in the form of block grant on an annual basis. According to media report, a combination of user-pay, government subsidies and medical insurance seem to be favoured by the new Secretary for Health and Welfare. This is a distinct departure from the approach of his predecessor Dr. E.K. Yeow who favoured the "Medisage", a savings account approach to solving Hong Kong's healthcare financing problem.

Review of Hong Kong healthcare delivery and healthcare financing problem has been going on for nearly ten years. The 1999 "Harvard Report" and the 2001 "Healthcare Consultation"[2] were milestone studies made by the HKSAR Government on healthcare system and healthcare financing reform. For the purpose of this article, we would like to point out that our intention is not to step outside our area of expertise as costing and cost management specialists. However, it should be noted that the problem arises out of the fact that, unless some reform is introduced, Hong Kong may not be able to sustain a recurring healthcare budget of HK$31,862 million[3] (i.e. 14% to 15 % of public expenditure or 3% to 4% of Hong Kong's GDP).

Hong Kong's Departure from the UK Healthcare Delivery Model

Hong Kong has departed from the UK model of healthcare services delivery since the creation of the Hospital Authority in 1990. In the UK, the Department of Health is still the supervising authority of all healthcare delivery services. This is similar to the combination of Hong Kong's Department of Health and the Hospital Authority.

In the UK, the National Healthcare Services (NHS) is structured as follows: there are 28 Strategic Health Authorities (SHAs) each covering a geographic area. Within a SHA there are Primary Care Trusts (PCTs) and Secondary Care Trusts (Normally called NHS Trusts). An NHS Trust is made up from one or more acute hospitals. A PCT looks after community care (GPs, district nurses, and so forth) and funds the acute hospitals through a commissioning process that has basically been an annual contract. The best way to get an understanding of what is happening to recent healthcare financing reforms done in the UK peruse www.dh.gov.uk and www.nhs.uk or do key word searches on the internet for phrases such as: "Payment by results", "Financial flows", "National tariffs NHS", "HRG NHS" and "Patient choice".

In the UK, if hospitals can become more cost effective than average they may make a "profit" which they can keep. This is to reward efficient hospitals. The UK is also moving towards the direction of paying hospitals by unit of services performed and not in the form of block grants.

Payment by Results and Activity-based financing for hospital care

HRG (Healthcare Related Group) is also known as DRG (Diagnostic Related Group) elsewhere in the world. DRG based payment was first used in the United States more than 20 years ago mainly for insurance claim purpose. DRG/HRG was introduced to Western Europe and Australia more than ten years ago for the purpose of healthcare financing

and hospital management. In essence, DRG/HRG is a standard grouping of medical or diagnostic procedures. Typical examples of DRG/HRG are "Child Birth" or "Hip Replacement". Under specific DRG/HRGs, a number of standard medical procedures or high-level groupings of standard medical activities are performed on the patient. In management accounting terms, the DRG/HRGs are the high-level "Activities" as well as "Cost Objects". And hospitals are typically paid by the number of DRG/HRGs performed on the patient plus number of "Bed Days", which can further classified as a "Normal Hospital Bed" or an "Intensive Care Unit Bed".

In the UK, the elective treatments are moving towards for DRG/HRGs based on a "National Tariffs" - a standard price which the NHS pays the hospitals. In 2004, some hospital income will be based on DRG/HRGs. Then each year more and more income for hospitals will be based on a longer list of DRG/HRGs. The "Patient Choice" scheme kicks in when a patient has been on a waiting list at a hospital for a period longer than, for example, six months. The patient can then choose another hospital with a shorter list and then the "value" of the operation will go with the patient to the other hospital. This is designed to pressure hospitals into reducing waiting lists so that they do not risk losing income. The "profit" and "choice" schemes are all about getting the clinicians to behave themselves and fall in line with market demands. This helps to ensure that resources are properly allocated and funding and time are not wasted. To maximize their income, individual hospitals will tend to build up their own medical specialties - a handful of DRG/HRGs that individual hospitals can deliver more efficiently than the other hospitals.

In Hong Kong, the resource allocation problem and the many of the anomalies caused by the current costing system could be solved if DRG/HRG was introduced. For example, DRG/HRG would be able to reflect the true costs of taking care of a young patient who broke his arm (but has no other medical procedures performed on him) and an elderly patient who broke his arm (who might have also have his kidney, heart and other potentially life-threatening medical conditions checked). Another anomaly is mainland mothers who choose to have their child born in Hong Kong for the sake of getting a Hong Kong ID Card for the child choosing to stay in the hospital for one day instead of the normal five days. Many mainland mothers, at a substantial risk to themselves and to the babies, would check in at mid-night and leave within 24 hours so that they are only charged HK$3,300 per-day non-resident bed rate. Charging mainland mothers for the medical procedure (i.e. DRG/HRG) of a "Child Birth" (approximately HK$14,000 - 15,000 at cost) plus the number of "Bed Days" (normally 5 days at say HK$700 per day) will help to eliminate this cost-induced behavior which causes considerable medical risk to the mother and child. This would also ease the extreme pressure put on the front-line staff who have to compress a normal 5-day long DGR/HRG into 24 hours.

Experience with DRG-based funding as a major part or all of hospital revenue in Europe

In the UK and virtually all countries in the developed world, private sector hospitals have DRG/HRG based price lists for various operations. These are used by patients and insurance companies. The NHS in the UK is beginning to buy large chunks of service from the private sector to help get waiting lists down. Private hospitals in the UK also need to know the true and accurate cost of their operation because they need to know the large chunks of volume of NHS work won is good business, particularly after a year when contracts are renegotiated.

In the case of Hong Kong, a future initiative by the HKSAR Government might make the knowledge of management accountants more relevant as a decision support tool for healthcare financing and healthcare management. For example, some elective procedures could be outsourced to private hospitals at standard DRG/HRG rates. This is not to say that introduction of DRG/HRG will solve all problems or that there is no downside risks to the introduction of DRG/HRG viz-a-viz the intended policy outcome of the HKSAR Government. It should be noted that most public healthcare systems in Western Europe are only partially financed by DRG/HRG[4]:

- **USA**: 100% DRG-based (practiced for 20 years, but not everyone covered by health insurance)
- **Norway**: 60% block grant, 40% DRG-based (ABF (activity-based financing) mainly to help reduce waiting time)
- **Portugal**: gradually increased to 30% DRG-based in 1999 and 50% since 2002
- **Denmark**: 10% DRG-based, 90% block grant
- **Finland**: DRG not mandatory. Some hospitals use DRG solely for the purpose of benchmarking
- **Germany**: 100% DRG-based
- **UK**: Moving towards the direction of Germany.

Problems associated with DRG-based payments

The "risk" or uneasy factor could be reflected by the concern over the introduction of DRG/HRG in the UK in 2004. The most common complaint is that if the DRG/HRG pricing is below the true cost of providing the services, hospitals will reduce healthcare service to meet the cost. Payment by results or DRG/HRG payments gives incentive to reduce costs. But such cost cutting can also start to erode quality. With the exception of Germany, none of the European countries have gone for 100% DRG/HRG based financing of hospitals. Most countries in Europe have opted for a step-by-step approach. That is, introducing only a few DRG/HRG based financing in the first years and gradually introducing a higher level and more refined system of DRG/HRG financing. At this moment, European countries are at around a 50% level. The other 50% is still financed as block grants.

Nevertheless, experience with DRG/HRG in the developed countries is largely positive as it enables hospital to make changes to the contractual relationship between the government and the healthcare service providers - the hospitals. DRG/HRGs can always be refined and pricing policy made more flexible. This type of system, by far, is superior to the previous situation (i.e. current Hong Kong situation) where hospitals do not know their true cost and have no incentive for improvement since hospitals are financed by block grants. Survival and improvement of hospitals need to be linked to economics and efficiency - not just quality of services performed.

There is no perfect healthcare system in the world but costing is the link and management accountants hold the key

It should be pointed out that no territory in the world has a perfect healthcare system. In the United States where DRG is used extensively, only those who have private medical insurance are covered. A large proportion of the population, mainly the low income earners are not covered. In the case of Hong Kong, a highly subsidized public healthcare system covers everyone and offers protection to all individuals from significant financial risks that may arise from major or prolonged illnesses.[5] Even the "Harvard Report", which is critical of Hong Kong's healthcare system, praises Hong Kong for having a relatively equitable system and the Hospital Authority for bringing very specific improvement to the quality and efficiency to Hong Kong's public healthcare system. The problem with our existing system is that there is no coherent policy for costing and financing the healthcare services of Hong Kong, thus putting the sustainability of the current system at risk.

Hong Kong should not be copying the UK system, the American system or any European system. We probably cannot afford the healthcare benefits enjoyed by citizens of Norway, a country with a small population and abundant North Sea oil. But the healthcare system as practiced in the United States would also be unacceptable to Hong Kong. While we want those who have the means to do so pay for a larger proportion of their own healthcare costs, we cannot accept that patients (including mainland mothers who come for child birth) should go untreated because they have no means to pay.

Looking in to a "Crystal Ball", Hong Kong may yet choose to postpone making changes to our current healthcare costing and cost management system for a few more years because of politics, our still abundant financial means, and an overall conservatism amongst the established institutions and administrative units. Probably, the Hospital Authority is still not ready to accept the fact that it may be shut down because of persistent budget deficits faced by the HKSAR Government. But sooner or later, Hong Kong will have to change in line with the rest of the world. The foundation of those changes is not medical technology or politics, but a coherent healthcare policy based on sound economics and good management.

HRG/DRG based payment is not rocket science. It is a combination of common sense and Activity-based Costing. Hong Kong is also lucky to have no language barrier with the developed world which now uses English as the common language. There are plenty of mistakes and international experience we could learn from. Believe it or not, costing, cost management and management accounting are the nuts and bolts to improved healthcare economics in Hong Kong and management accountants hold the "wrenches" to tighten those nuts and bolts.

Accountants hold the keys to changes in Hong Kong's healthcare system!

[1] *South China Morning Post, Tuesday November 9, 2004, page A3*

[2] *Improving Hong Kong's Healthcare System - Why and for Whom?, School of Public Health, Harvard University, 1999 & Lifelong Investment in Health, Consultation Document on Healthcare Reform, Health & Welfare Bureau, HKSAR Government, 2001*

[3] *2004-2005 Budget: HK$28,962 million subvention to Hospital Authority and HK$2,900 million Department of Health expenditure*

[4] *"New Financial Flows for NHS Hospitals, English Policy, International Experience", published by Office of Health Economics, London http://www.ohe.org following a conference held on 31 March 2004.*

[5] *Lifelong Investment in Health, Consultation Document on Healthcare Reform, Health & Welfare Bureau, HKSAR Government, 2001*

Presidential Engagements

8 Sept	Cocktail Reception, The rebirth of the Hong Kong Society of Accountants as the Hong Kong Institute of Certified Public Accountants, HKSA
20 Sept	IRD Users' Committee Meeting, Inland Revenue Department
11 Oct	CGA Hong Kong Graduation Ceremony and Annual Dinner 2004, CGA Hong Kong
26 Oct	Award Presentation, The Hong Kong Business Mastermind Award - Where Great Minds Meet, East Week
30 Oct	Awards Ceremony for graduates of the BA (Hons) Accounting and Finance and BA (Hons) Business & Management, Leeds Metropolitan University
6 Nov	Honorary University Fellowship Presentation Ceremony and 15th Anniversary Banquet, The Open University of Hong Kong
17 Nov	The Award Presentation Banquet of 2004 Bauhinia Cup Outstanding Entrepreneur Awards, The Hong Kong Polytechnic University
20 Nov	Asia's Financial Centre - Challenges and Opportunities, CGA Hong Kong
25 Nov	Annual Dinner 2004, HKICPA
26 Nov	Annual Dinner cum Graduation, Postgraduate Diploma in Professional Accountancy 2003-4, The Chinese University of Hong Kong
30 Nov	2004 Graduation Ceremony of the Systems, VTC's Hong Kong Institute of Vacational Education and the School of Business and Information
1 Dec	2nd Graduation cum Scholarship Award Ceremony, The Community College at Lingnan University
14 Dec	Anniversary Luncheon of ISCOPS and Silver Jubilee of Professional Courses, Hong Kong College of Technology
17 Dec	Budget Consultation, Financial Services and the Treasury Bureau, HKSAR

The 55th National Day Celebration Dinner

A dinner was held on 27 September to celebrate the 55th National Day which was organized by the Society of Chinese Accountants & Auditors and co-sponsored by AIA, ACCA, CGA-Canada, CIMA, CMA-Canada, CICPA, CPA Australia, HKAAT and ICAA.

▲ Smiling faces! From left to right: Mr. S Y Choi, Council Member, Mr. Teddy Iu, CIMA Hong Kong Division Past President and members of the Community Services Committee Miss Anita Leung & Ms. Amy Lam

▲ Mr. Paul Yeung, President of CIMA Hong Kong Division meet up with Mr. Gao Jing, Division Chief, Coordination Department, Liaison Office of The Central People's Government in the HKSAR

▲ Ms. Juliee PL Tan, Head of Branch Affairs Hong Kong, Ms. Irene Cheng, Council Member and Mr. Robert Jelly, Director of Education CIMA at the cocktail reception

Joint Seminar

▲ On 11 September, a seminar jointly organised with CGA Hong Kong on the "Operational Resource Management" presented by Dr. Horace Yuen, Dr. Joseph Yau and Mr. Alan Lung attracted 50 participants. Lots of questions were raised in the Q&A session. Thanks go to KH Lau for chairing the seminar.

▲ From left to right: Dr. Horace Yuen, Mr. KH Lau, Mr. Alan Lung and Dr. Joseph Yau after the souvenir presentation