Submission on Regulation of Private Healthcare Facilities
Ares Leung
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Via email and fax
Personal contacts to Dr Ares Leung
Telephone
Email
Address:

Brief Professional Profile of Ares Leung

This is a personal submission by Dr Ares Leung. He is a local medical practitioner and holds the following capacities.

Deputy Medical Director, Management Board Member, & member of Medical Advisory Committee, Union Hospital, a private hospital in HK.

Founder of several medical groups housing more than 30 specialist doctors.

HK Surveyor of ACHS(I) (Australia-based hospital accreditation system)

President of Hong Kong College of Obstetricians and Gynaecologists

Just retired member of Education and Accreditation Committee of HK Medical Council (after 2 terms of 3 year service)

Honorary academic staff of both HKU and CUHK

Examiner of HKU, CUHK, HK College of O&G, Royal College of O&G

Completion of Mediator training

Submission

It is appropriate that the government takes initiatives to regulate private healthcare facilities, in relation to anticipated increase in contribution of private sector to medical care. Flexibility in sanction activities away from an across-the-board continuation versus discontinuation of license to practice is a reasonable improvement.

The approach to manage facilities for **ambulatory special, especially invasive, treatment** is also an improvement from previous government approaches, with plan to engage professional bodies involved in standard regulation, such as Academy of Medicine in future. It may further be advised that peer review among service providers may serve many purposes in future implementation. There will be engagement of service providers, automatic feedback and saving in manpower needs.

It is appropriate to move away from already less useful entities such as 'clinics'. Also, it is right to house maternity service only in licensed hospitals. It may be considered that all **childbirth facilities are accredited by a standard regulator on top to hospital wide accreditation**. One existing provider to this mode of accreditation is the HK College of Obstetricians and Gynaecologists. It may be explained here that hospital wide accreditation programs, be it ACHS, JCI, ISO or any other scheme, looks at overall hospital services. Service accreditation by HKCOG is a very clinical program looking at hardware, manpower, governance, risk management, audits, support and practically everything related to childbirth and gynaecology services.

It is necessary to regulate **medical services under management of incorporated bodies**. It is wise to engage relevant stakeholders, particularly those with good reputation as recognized by other professionals at the start. Many decent big groups exist in town, and some of them have enjoyed good professional reputation. It may not be difficult to identify them. It is practically always essential to engage service providers in this category, instead of relying entirely on good faith and common sense. In addition, clear instructions, expectations and certain amounts of flexibility in the beginning may be important elements of success.

It is a right direction to develop a **centralized conflict resolution mechanism**, not just complaints as it was stated. Heavy input from service providers is necessary.

While it is public expectation that lay involvement is present, it is important that the mechanism communicates with service providers and understands reality and limitations. It may be of particular relevance that recently professional indemnity to obstetric services is changed unilaterally by its provider Medical Protection Society. The HK College of O&G may be involved to develop a HK wide conflict resolution mechanism in the private sector.

In modern day healthcare, governance and clinical quality assurance are mandatory requirements and the government is right to supervise on performance in these areas. However, the government and effector mechanisms should restrict the scope to mechanisms administered by an institution, instead of direct care by each doctor or micro-involvement with single incidents.

Price Transparency is a practical must nowadays. Patients need full briefing about costs involved before embarking on treatment. It is an essential component to help making decisions for choice of provider(s) by clients. My own teams of doctors all do so routinely and patients are usually satisfied. However, when there is formal need to use forms, some difficulty is encountered.

Financial estimation is a responsibility of the doctors instead of private hospitals. A hospital may audit on accuracy and assist the doctor but cannot prospectively do it for the doctor. Nor may a hospital be bound by what the doctor estimates to be the expenditure. Such views are based on traditional emphasis on confidentiality and trust between the doctor and his client in western medicine. A hospital cannot possibly know the exact communication between the doctor and the patient in a consultation room, and it is unethical if the hospital even tries to influence this process.

In the long term, it is necessary that each hospital assists her doctors with IT systems. My support in Union Hospital is already working on establishment of a database resting on diagnosis and plan on admission, a prospective event; instead of a retrospective discharge diagnosis. Doctors may then assess on line their own expenditure profile based on previous patients, or entire hospital statistics. This may become good customer service to doctors from hospitals. I expect my project to bear fruit within a year.

Immediately, hospitals may facilitate doctors with information about patient expenditures, e.g., alongside monthly payment statements which the doctor

certainly reads.

A next step could be reflection to accuracy of financial estimation by the hospital. A doctor may explain his charges (expected to be very accurate), charges from his medical companions (expected to be fairly accurate), and give an idea about special costly items (which should be fairly accurate), and hospital costs (expected to be an estimation only). The hospital merely establishes a mechanism to inform the patient / family and the doctor when the estimated amount is reached but the patient is not yet discharged. Such work allows the doctor to 'reset' his estimation and a chance that the patient and family receives additional counselling. The doctor has immediate feedback when his original estimation is inaccurate, and he will adapt in his next admission.

The hospital may also conduct regular audits on accuracy of financial estimation. Doctors who fare poorly in performance may then be alerted.

Package charges has been a feature of Union Hospital. It is sad that such efforts now seen as appropriate to society, and initiated more than a decade ago, is constantly enjoying negative support from the insurance industry. Our packages are uniformly declined by clients and insurance agents because claim forms need categorized entries on expenses. The insurance sector seems not interested to help us develop these products.

It is useful to group matters under umbrella of a new **regulatory body**. At the same time, wide representation and involvement of service stakeholders is useful. Care in private medicine is complicated and limitations do exist, and it is necessary to let other parties understand these issues.