Chapter 2  Healthcare Reform – Progress To Date

2.1  The Government’s commitment to healthcare is set to continue to increase as we reform the healthcare system based on the community’s views. We will continue to uphold the public healthcare system as the safety net for the whole population. The Government’s annual recurrent expenditure on health has increased from $30.5 billion in 2007-08 to $36.9 billion in 2010-11. We aim to increase the health budget to 17% of the Government’s recurrent expenditure in 2012.

2.2  Following the first stage public consultation, the Government has been taking forward various healthcare service reform proposals which have broad support in the community, including enhancing primary care, promoting public-private partnership, development of electronic health record (eHR) sharing, and strengthening public healthcare safety net. The progress in taking forward these service reforms is summarized in the following sections.

(1) Enhancing Primary Care

2.3  Effective primary care can often improve the health of individuals in the community, and reduce their need for more expensive medical services especially specialists and hospital services. However, holistic primary care, especially preventive care and wellness promotion, is not sufficiently emphasized at present. The Government has therefore proposed to enhance primary care by focusing on the provision of continuous, comprehensive and holistic primary healthcare services, with special emphasis on prevention.

Primary Care Development

2.4  Following the Chief Executive’s announcement in the 2008-09 Policy Address that the Government would allocate resources to implement the proposals to enhance primary care, the Secretary for Food and Health reconvened the Working Group on Primary Care (WGPC) under the Health and Medical Development Advisory Committee (HMDAC) in October 2008 to provide strategic recommendations on enhancing and developing primary care in Hong Kong. The WGPC comprises representatives from medical professionals from the public and private sectors, academia, patient groups and other stakeholders. Three Task Forces were set up under the WGPC to study specific proposals set out in the consultation document, taking into account the views collected during the first stage public consultation on healthcare reform.

2.5  After extensive deliberations at both the Task Forces and other informal forums, the WGPC has formulated a set of initial recommendations in 2009 for the development of better primary care services in Hong Kong through the following three main areas of work –

(a) developing primary care conceptual models and clinical protocols, especially for
the prevention and management of common chronic diseases, starting from hypertension (HT) and diabetes mellitus (DM), the two most common chronic diseases in Hong Kong, with a view to guiding the provision of enhanced primary care;

(b) setting up a Primary Care Directory with a view to promoting enhanced primary care through the family doctor concept and adopting a multi-disciplinary approach, starting from the sub-directories for doctors and dentists; and

(c) devising feasible service models to deliver enhanced primary care services in the community through pilot projects as appropriate, including the setting up of community health centres (CHCs) or networks.

(a) Conceptual Models and Clinical Protocols

2.6 After more than a year of extensive formal and informal discussion sessions among the WGPC and Task Force members and experts in the field, the primary care conceptual models and clinical protocols for HT and DM are being finalised for use as common reference by healthcare professionals. We aim to launch the first edition of the models and protocols within 2010-11. The strategies for promoting the clinical protocols to the public and healthcare professionals are also being developed. Next the WGPC and the relevant Task Force will start developing age group-specific models and protocols, e.g. children and elderly.

(b) Primary Care Directory

2.7 On the Primary Care Directory, members of the WGPC have agreed on the information to be provided in the Directory, as well as the criteria for entering and remaining in the Doctor and Dentist sub-directories at the initial stage of development of the Directory. We aim to launch the first edition of the Doctor and Dentist sub-directories within 2010-11. The Government will continue to work with the healthcare professionals, academia and relevant stakeholders to explore the enhancement in professional requirements for entering and remaining in the Directory in the future, and other issues such as training and manpower development of primary care providers. The sub-directories of Chinese medicine practitioners, nurses and other allied health professionals will be developed at a later stage.

(c) Community Health Centres and Networks

2.8 With regard to the primary care service delivery models, the Government is exploring various CHC pilot projects based on different models in consultation with healthcare professionals and providers from the public and private sectors, non-governmental organisations (NGOs) and the universities. Located in the community, CHCs aim to offer the public with one-stop, better co-ordinated, and more comprehensive primary care services.
Pilot Initiatives to Enhance Primary Care

2.9 Since end 2008, the Government has taken forward, through the Department of Health (DH) and the Hospital Authority (HA), various initiatives in providing primary care and public health services, engaging different primary care professionals from the private sector and enhancing the involvement and collaboration of the private sector with the public sector. These include –

- Elderly Health Care Voucher Pilot Scheme
- Elderly Vaccination Subsidy Scheme
- Childhood Influenza Vaccination Subsidy Scheme

2.10 Besides, the Government has implemented a series of pilot projects through HA to strengthen chronic disease management in the primary care setting, some of which involve partnership between the public sector and the private sector and NGOs. These projects include –

- Multi-disciplinary Risk Factor Assessment and Management Programme (RAMP)
- Patient Empowerment Programme (PEP)
- Nurse and Allied Health Clinics (NAHC)
- Public-Private Chronic Disease Management Shared Care Programme
- Tin Shui Wai Primary Care Partnership Project

(a) Multi-disciplinary Risk Factor Assessment and Management Programme (RAMP)

2.11 Under this programme, multi-disciplinary teams of healthcare professionals including nurses, dieticians and pharmacists are set up by HA in designated general out-patient clinics (GOPCs) to provide comprehensive health risk assessment for HT and DM patients, so that they can receive appropriate preventive and follow-up care.

2.12 The programme has been implemented in the Hong Kong East and New Territories East Clusters of HA since August 2009. It will be implemented in 23 GOPCs in six clusters (including Hong Kong East, Hong Kong West, Kowloon East, Kowloon Central, Kowloon West and New Territories East Clusters) in 2010-11, and will be extended to all seven clusters across the territory by 2011-12. A total of 144,500 patients are expected to benefit from the programme by 2012-13.

(b) Patient Empowerment Programme (PEP)

2.13 HA has implemented this programme in collaboration with NGOs starting from March 2010 to improve chronic disease patients’ knowledge on the diseases and enhance their self-management skill. A multi-disciplinary team comprising allied health professionals from HA develops appropriate teaching materials and aids for common chronic diseases (for example, HT, DM, chronic obstructive pulmonary disease, heart
disease, etc.), and provides training for frontline staff of the participating NGOs to facilitate the organisation of patient empowerment sessions.

2.14 The programme will be extended to all seven HA clusters by 2011-12, serving a total of 32,000 patients over 3 years.

(c) Nurse and Allied Health Clinics (NAHC)

2.15 NAHCs comprising HA nurses and allied health staff have been established by HA in selected GOPCs in its seven clusters starting from August 2009 to provide more focused care for high-risk chronic disease patients, including those who require specific care services for health problems or complications. These services include fall prevention, handling of chronic respiratory problems, wound care, continence care, drug compliance and supporting mental wellness for individual patients. The total number of attendances is expected to be 217,400 by 2011-12.

(d) Public-private Chronic Disease Management Shared Care Programme

2.16 The Shared Care Programme is a pilot project which offers additional choices to chronic disease patients currently under the care of the public healthcare system to have their conditions followed up by private doctors. Clinically suitable patients are identified by a multi-disciplinary risk assessment and management programme at special outpatient clinics and then invited to participate in the Shared Care Programme. The Government provides partial subsidy for patients to receive comprehensive management in the community, and supports the establishment of long-term partnership between patients and the doctors of their choice. The programme primarily targets DM and HT patients who are currently taken care of by the public healthcare system.

2.17 The programme is currently being piloted by HA in the New Territories East Cluster. Independent assessment bodies are engaged in the continuous evaluation of programme process and effectiveness. The Government will consider improving and extending the programme to other districts having regard to the initial experience. Resources have been reserved to benefit 22,000 patients by 2012-13 under the programme.

2.18 The above pilot projects aim at trying out different service models for enhancing primary care both within the public healthcare system and through partnership with the private sector and NGOs. The Government will continue to plan various pilot projects to foster the provision of CHC-type services or formation of CHC networks, and explore different models of service provision in consultation with the relevant stakeholders.

Strategy for Primary Care Development

2.19 The overall strategy for developing primary care in Hong Kong is an on-going and evolving strategy which emphasizes a step-by-step and consensus building approach to reforming the primary care system, and a virtuous cycle of pilot-evaluation-adjustment for the continuous development and implementation of specific initiatives and pilot projects. Based on the recommendations of the WGPC, we plan to publish a strategy
document by the end of 2010 to set out the overall strategy for primary care development in Hong Kong.

2.20 As part of the strategy, the Government will also launch a two-year advocacy campaign at the same time in partnership with healthcare professionals to raise public awareness of the importance of primary care in disease prevention and management, and encourage the public to adopt good primary care practices and a proactive approach in improving health.

2.21 A Primary Care Office (PCO) has been set up in DH in September 2010 to support and co-ordinate the long-term development of primary care in Hong Kong, the implementation of primary care development strategies and actions, and the co-ordination of actions among DH, HA, private healthcare sector, NGOs and other healthcare providers.

Way Ahead

2.22 With the continuous evolution and implementation of the strategy for primary care development, we expect to see the following next steps in the course of enhancing primary care in Hong Kong –

(a) We plan to launch the first editions of the primary care conceptual models and clinical protocols for DM and HT within 2010-11. Age group-specific primary care conceptual models and clinical protocols for children and the elderly will also be developed.

(b) We plan to launch the first edition of the Doctor and Dentist sub-directories of the Primary Care Directory within 2010-11. The sub-directories of Chinese medicine practitioners, nurses and other allied health professionals will be developed at a later stage.

(c) We will continue to take forward, through DH and HA, a series of pilot projects to enhance primary care, including various healthcare voucher and vaccination subsidisation schemes, the Shared Care Programme and other chronic disease management pilot projects that aim at trying out different models for enhancing primary care both within the public healthcare system and through public-private partnership.

(d) We will continue to explore various CHC pilot projects based on different CHC-type models in consultation with healthcare professionals and providers from the public sector, private sector, NGOs, and the universities, to tie in with the different needs of the local communities where these pilot projects will be situated.

2.23 In terms of resources, the Government has been providing and will continue to provide financial support to the long-term task of developing primary care, where
necessary, having regard to the overall progress of healthcare reform including supplementary healthcare financing arrangements and the resources available for healthcare. An additional funding of more than $4.1 billion has been allocated and earmarked for primary care and Public-Private Partnership (PPP) in Healthcare since 2008-09.

(2) Promoting Public-Private Partnership (PPP) in Healthcare

2.24 PPP offers greater choice of services for individuals in the community, promotes healthy competition and collaboration among healthcare providers, makes better use of resources in the public and private sectors, benchmarks the efficiency and cost-effectiveness of healthcare services, and facilitates cross-fertilization of expertise and experience between medical professionals.

PPP Pilot Projects and Initiatives

2.25 To promote PPP in healthcare, the Government has implemented a number of PPP projects such as the Tin Shui Wai Primary Care Partnership Project under which primary care services are purchased from the private sector in Tin Shui Wai for specific patient groups under the care of public GOPCs, the Public-Private Chronic Disease Management Shared Care Programme, the purchasing of haemodialysis service from private centres for end stage renal disease patients currently under the care of public hospitals, and the Cataract Surgeries Programme where patients waiting for cataract surgeries in public hospitals receive partial subsidy to receive treatment in the private sector. Since the introduction of the Cataract Surgeries Programme in 2008, more than 10,000 patients have joined the programme and over 7,500 of them have already undertaken surgeries as at July 2010. HA's target is to provide additional 3,000 surgeries under the programme in 2010-11.

2.26 The Government has also implemented the Elderly Health Care Voucher Pilot Scheme, which is a three-year pilot scheme, starting from 1 January 2009. Under the Scheme, all citizens aged 70 or above are given annually five healthcare vouchers worth $50 each through an electronic system to partially subsidise their use of primary care services in the private sector. The Scheme aims at implementing the “money-follows-patient” concept on a trial basis through the provision of partial subsidy to the elderly. It enables the elderly to choose private primary care services that best suit their needs in the community, thereby piloting a new model for subsidised primary care services in the future. It also lays the foundation for the future development of subsidisation schemes by vouchers for enhancing primary care services for specific age groups or disease groups.

2.27 Moreover, the Government introduced in 2008-09 a number of vaccination schemes through PPP. These included a childhood influenza vaccination subsidy scheme and a vaccination subsidy scheme for the elderly to increase the number of vaccination service providers and to offer more choices of providers to the public. The aim is to
encourage target groups to receive vaccination in the private sector to minimize the risk of infection of infectious diseases.

2.28 Building on the experience gained and the infrastructure established for taking forward the above PPP initiatives, the Government will continue to examine possible PPP initiatives with a view to making the best use of healthcare resources in the public and private sectors to deliver better healthcare services.

Table 2.1 Summary of the pilot projects involving public-private-partnership in healthcare

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Details</th>
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<tbody>
<tr>
<td><strong>Cataract Surgeries Programme</strong></td>
<td>The Cataract Surgeries Programme has been launched to shorten patients’ waiting time on HA's queue for cataract surgeries.</td>
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<tr>
<td></td>
<td>Eligible patients on HA's waiting queue for cataract surgeries are invited to participate in this Scheme.</td>
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<td></td>
<td>HA provides a one-off $5,000 subsidy for participating patients to undergo cataract surgeries in the private sector, and any balance of the surgery fee will be borne by the patients concerned. Private surgeons may charge no more than $13,000 for each surgery; the patients are thus required to co-pay at most $8,000 for the cataract surgery performed. For eligible patients who are recipients of CSSA or from low-income families eligible for full medical waiver, they may have cataract surgeries performed in HA hospitals through additional operating sessions.</td>
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<tr>
<td><strong>Tin Shui Wai Primary Care Partnership Project</strong></td>
<td>The Tin Shui Wai (TSW) Primary Care Partnership Projects has been launched to test the use of PPP model and supplement the provision of public general out-patient services in the area.</td>
</tr>
<tr>
<td></td>
<td>Under this Programme, eligible patients in TSW who have been under the care of HA's existing TSW GOPC are invited to participate. Those who choose to participate in this Scheme may enrol with a private medical practitioner in TSW who participates in this Scheme. They may seek up to 10 medical consultations with the private practitioners, and are required to pay a standard fee of $45 per consultation, the same fee as attending HA's GOPC.</td>
</tr>
<tr>
<td><strong>Haemodialysis Shared Care Programme</strong></td>
<td>The Haemodialysis Shared-Care Programme has been launched to utilize spare capacity in the private sector in providing haemodialysis services.</td>
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<td></td>
<td>Under the Programme, eligible patients with end stage renal disease currently under the care of HA will be invited to participate. Qualified community haemodialysis providers in the private sector will provide haemodialysis treatment to patients who choose to participate. Patients participating in the programme will pay the community haemodialysis centre/private hospital a standard fee ($80), the same as that for receiving haemodialysis treatment in HA hospitals.</td>
</tr>
<tr>
<td><strong>PPP Project on Enhancement of Radiological Investigation Services</strong></td>
<td>The purpose of the Project is to subsidise patients under the care of HA to receive radiological investigation service in the private sector as an additional choice for the patients, having regard to the spare capacity in the private sector to provide such service.</td>
</tr>
<tr>
<td></td>
<td>Eligible patients will be invited to receive radiological imaging service through specified contracted private providers.</td>
</tr>
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### Elderly Health Care Voucher Pilot Scheme

During the three-year period of the Pilot Scheme, all elderly with HK Identity Card at or above the age of 70 are provided each year with five vouchers of $50 each as partial subsidies for their receiving primary care services from private primary care providers enrolled under the Scheme (covering 9 healthcare professions including doctors, dentists, Chinese medicine practitioners, etc.).

Eligible elderly may choose freely to use one or more of the vouchers to pay for primary care services they received from enrolled private primary care providers, but are required to pay any balance of the fees that may be charged by the providers on top of the voucher amount.

### Elderly Vaccination Subsidization Scheme, Childhood Influenza Vaccination Subsidization Scheme and Human Swine Influenza Vaccination Subsidization Scheme

A number of vaccinations for certain high risk groups are recommended by Scientific Committees comprising relevant experts to minimize the risk of infection and hospitalization. In this regard, a number of vaccination subsidization schemes have been launched to subsidize eligible individuals receiving vaccination from private medical practitioners who are the predominant primary care providers for the population.

Eligible individuals are provided a fixed amount of subsidies when they receive vaccination from a private medical practitioner enrolled under the schemes. The practitioner may charge extra fees for the vaccination which have to be paid by the individuals, subject to the extra fees being indicated upfront to the Government and on a poster in the clinic. In the case of Human Swine Influenza Vaccination, extra subsidies are provided for the injection costs and practitioners are encouraged not to charge extra. However, no restriction is set on charging co-payments.

### Shared Care Programme

Currently, chronic disease patients who receive treatment at HA's Specialist Out-patients Clinics (SOPCs) and are clinically stable can be referred to neighbouring public GOPCs to follow up on their conditions. The Shared Care Programme provides additional choices of private services for these patients and allows patients to choose neighbouring private doctors of their choice to follow up on their conditions and receive partial subsidy for receiving comprehensive management. Doctors may charge the patient an extra fee that will have to be made transparent upfront to both the Government and the participating patients. The programme aims to establish long-term patient-doctor relationships in order to achieve the objective of continuous and holistic care. The public healthcare system will continue to provide support to participating patients.

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**Centres of Excellence and Private Hospital Development**

2.29 The Government is also preparing for the establishment of multi-partite medical centres of excellence in the specialty areas of paediatrics and neuroscience in Hong Kong. They are part of the Government’s pilot measures to promote excellence in medical specialties and PPP, as stated in the Chief Executive’s 2008-09 Policy Address. The two centres will bring together professionals in the public, private and academic sectors from both within and outside Hong Kong to provide multi-disciplinary care for patients suffering from these complex diseases, and to conduct research and training in the two specialty areas of paediatrics and neuroscience.

2.30 In addition, as part of our healthcare reform initiatives to improve the long-term sustainability of our healthcare system, and in line with the Government’s policy to promote and facilitate development of private hospital and medical services, the Government is promoting and facilitating private hospital development in order to address the imbalance between the public and private sectors in hospital services and to increase the overall capacity of the healthcare system in Hong Kong to cope with the
increasing service demand.

2.31 To this end, the Government has reserved four sites at Wong Chuk Hang, Tseung Kwan O, Tai Po and Lantau for private hospital development. For formulating suitable land disposal arrangement, the Government has invited local and overseas parties to express their interest in developing private hospitals at the reserved sites. We have received a total of 30 expression of interest submissions upon the deadline on 31 March 2010. We are considering the suggestions and views in the submissions received with a view to formulating the land disposal arrangements for the four reserved hospital sites, including the means and timing for land disposal, the detailed service and special requirements, and the land premium.

2.32 To ensure that the services provided by the new hospitals would be of good quality, cater for the needs of the general public, and help enhance the professional standards and ethics for furthering the development of medical services, the Government will formulate a set of special requirements for development of the sites, which cover the aspects of scope of service, price transparency, service standard, etc.

2.33 In respect of price transparency, the Government is considering requiring the private hospitals to be developed at the four sites to provide a certain volume of services through packaged charging, which should cover doctors’ fees, maintenance fees, diagnostic procedures, surgical operations, etc. We believe such requirement could help enhance price transparency and hence provide incentives for the public to use private hospital services.

(3) Developing Electronic Health Record Sharing

2.34 The territory-wide patient-oriented eHR sharing system connecting the public and private healthcare providers is an essential infrastructure for implementing the healthcare reform. The objective of an eHR sharing system is to enhance the continuity of care as well as better integration of different healthcare services for the benefits of individual patients. Participation in eHR sharing is voluntary and based on patients’ express and informed consent. The Government has taken a leading role in eHR development given the multitude of healthcare providers involved and the importance of personal health data.

2.35 A dedicated eHR Office was set up under the Food and Health Bureau in July 2009 to steer and oversee the ten-year eHR Programme (from 2009-10 to 2018-19) with a view to ensuring coherent development in both the public and private sectors. The Government will leverage the successful experience and invaluable expertise of HA in developing its Clinical Management System (CMS) since 1995. The HA CMS is the largest integrated electronic medical/patient record (eMR/ePR) system in Hong Kong and has more than eight million medical records. The Government will make available HA’s systems and know-how to facilitate the private sector in developing their eMR/ePR systems with sharing capabilities through different partnership initiatives such as the eHR
2.36 The eHR sharing system will bring about a host of benefits to the community through a healthier population and a reduction on secondary and tertiary care costs as a result of more effective and early treatment. Also, the system would enhance the availability and transparency of information through sharing of patient records between healthcare providers in both the public and private sectors, reduce the number of consultations, improve the accuracy of diagnosis and patient management through clinical decision support, minimise duplicate investigations and errors associated with paper records, enable disease surveillance, public health research and more effective policy formulation.

First Stage eHR Programme

2.37 The objectives of the First Stage eHR Programme (from 2009-10 to 2013-14) are –

(a) to set up the eHR sharing platform by 2013-14 for connection with all public and private hospitals;

(b) to have eMR/ePR systems and other health information systems available in the market for private doctors, clinics and other health service providers to connect to the eHR sharing platform; and

(c) to formulate a legal framework for the eHR sharing system to protect data privacy and system security prior to commissioning of the system.

2.38 The 10-year eHR programme is estimated to cost a total non-recurrent expenditure of $1,124 million and an annual recurrent expenditure of around $200 million. In July 2009, the Finance Committee of the Legislative Council approved a new capital commitment of $702 million for implementing the First Stage eHR Programme.

2.39 With these funding, the eHR Office, under the guidance of the Steering Committee on eHR Sharing comprising members from both the public and private sectors, will spearhead and co-ordinate the ten-year programme which covers –

(a) the eHR Core Infrastructure Architecture for the territory-wide eHR sharing platform;

(b) the CMS Adaptation Modules and On-ramp Applications to private sector for developing their individual eMR/ePR systems;

(c) standardisation of technical standards to facilitate accurate sharing of clinical data;

(d) different partnership initiatives including eHR Engagement Initiative to invite partnership proposals that would contribute towards the development of eHR sharing system;
(e) various engagement and briefing sessions with stakeholders and the public to raise public interests in and awareness of eHR; and

(f) Privacy Impact Assessment, Privacy Compliance Audit, Security Risk Assessment and Security Audit and drafting of the necessary legislation to safeguard data privacy and ensure the integrity of the eHR sharing system.

Pilot Projects on eHR Sharing

2.40 Prior to the implementation of the eHR sharing system in 2013-14, pilot partnership projects have been initiated to facilitate better collaboration on sharing of electronic medical records between the public and private healthcare sectors subject to patients’ consent. The Public-Private-Interface Electronic Patient Record Sharing Pilot Project, which was first launched in 2006, will be expanded to NGOs to allow more patients and private healthcare providers to experience the sharing of electronic patient records. The Radiological Image Sharing Pilot Project, which was launched in 2009, will be extended to interested private healthcare providers for sending radiological images of enrolled patients to HA via electronic means.

(4) Strengthen Public Healthcare Safety Net

2.41 The current public healthcare system serves as an essential safety net for the population, especially those who lack the means to pay for their own healthcare. The Government will continue to uphold the public healthcare system as the safety net for the whole population and to provide highly-subsidized public healthcare services targeting those in need. To strengthen this safety net to cope with the increasing service demand arising from the growing and ageing population, the Government has been increasing the funding for public healthcare service in recent years.

Improving Public Healthcare Services

2.42 The Government has been increasing the financial provision for HA since 2007-08. The subvention of HA in 2010-11 is around $32.7 billion, up from $28.0 billion in 2007-08, representing an increase of 17% over that for 2007-08. Under the three-year funding arrangement for the HA starting from 2009-10, HA’s recurrent subvention will be further increased in 2011-12. The additional provision allocated to HA will be used for implementation of a host of improvement measures, which include the following major items with respect to reducing waiting time of public hospital services and improving the coverage of standard public services –

(a) expansion of service capacity in the Hong Kong East, Kowloon East and New Territories West Clusters through opening of additional beds and operating theatre suites;

(b) enhancement of services for treatment of life-threatening diseases, including haemodialysis service, palliative care for patients with end stage renal diseases,
clinical oncology service, integrated cancer care and acute cardiac care;

(c) introduction of a case management programme on cancer treatment;

(d) enhancement of mental health services through new initiatives including introduction of the case management programme for persons with severe mental illness and enhanced assessment and treatment for persons with common mental disorders through the setting up of Common Mental Disorder Clinics and introduction of the Integrated Mental Health Programme;

(e) expansion of the coverage of HA’s Drug Formulary by including eight new drugs as standard drugs and expanding the clinical application of twelve drug classes;

(f) strengthening the supply of nursing manpower through provision of nurse training places;

(g) increasing the number of cataract surgeries; and

(h) establishment of a specialist centre for joint replacement.

2.43 The Government also plans to increase the number of beds in public hospitals. The planned number of beds in public hospitals managed by HA is 27,041 by March 2011. A number of redevelopment/expansion projects of existing public hospitals and new public hospital projects are underway, including the expansion of the Tseung Kwan O Hospital, the North Lantau Hospital Phase 1 and the Tin Shui Wai Hospital. It is estimated that about 600 additional beds in public hospitals will be provided over the next few years.

**Strengthening Safety Net Mechanisms**

2.44 Meanwhile, the current fee waiver mechanism and other financial assistance schemes for certain self-financed drug items and privately-purchased medical items through the Samaritan Fund will continue to be available to recipients of Comprehensive Social Security Assistance and low-income families. The Government will continue to monitor the use of the Fund and will inject additional money into the Fund where necessary (the Government has injected $1 billion into the Fund in 2008-09 to cope with the projected requirements of needy patients).

2.45 At the same time, we are exploring with HA on other possible ways to further strengthen the safety net, especially for patients requiring costly treatment. This includes exploring the idea of providing a second safety net in the form of additional financial assistance for those patients requiring costly treatment when their medical expenses for public healthcare services exceed a certain proportion of their household income. The idea is to provide them with an additional protection against financial ruin when struck by catastrophic illnesses. We will also explore rationalization of the existing subsidization structure of public healthcare services with a view to ensuring that subsidies are accorded to those most in need.